MIDTERM EVALUATION OF THE JORDAN FAMILY HEALTH SERVICES PROJECT (278-0287)

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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ACKNOWLEDGMENTS

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ABBREVIATIONS

ABFP	American Board of Family Practice
AUB	American University of Beirut
CA	Cooperative Agreement
CHS	Center for Human Services
CMIS	clinic management information system
CPP	Comprehensive Postpartum
EOP	end of project
EOPS	end of project status
FA	faculty advisor
FHS	family health services
FM	family medicine
FMS	family medicine specialty
FMSTP	Family Medicine Specialty training program
FP	family planning
GOJ	Government of Jordan
IEC	information, education, and communication
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JAFPP	Jordan Association for Family Planning and Protection
JHU	Johns Hopkins University
JMC	Jordan Medical Council
JUST	Jordan University of Science and Technology
KAP	knowledge, attitudes, and practice
MBS	Marketing of Birth Spacing
MCH	maternal and child health
MCRA	married couples of reproductive age
MOH	Ministry of Health
MOU	memorandum of understanding
MQC	Monitoring and Quality Control
MQCD	Monitoring and Quality Control Directorate
NGO	nongovernmental organization
NPC	National Population Commission
PFH	USAID Population and Family Health Office
PHC	primary health care
PI	principal investigator
PPM	Planning and Projects Management
RMS	Royal Medical Service
RP	results package
QA	quality assurance

QOC	quality of care
SO	strategic objective
SO3	Strategic Objective No. 3
TA	technical assistance
TOT	training of trainers
UOJ	University of Jordan
URC	University Research Corporation
USAID	United States Agency for International Development

ABSTRACT

The midterm evaluation of the US$7 million eight-year (August 1990-September 1998) Family Health Services (FHS) Project was conducted in February 1996. The project has two major components: 1) Family Health Services Delivery, including quality assurance and family planning activities, and a Family Medicine Specialty training program and 2) assistance to nongovernmental organizations including the National Population Commission and the Jordanian Association for Family Planning and Protection.

Based on the findings coincident to this evaluation, it is apparent that the quality assurance concept has been embraced with enthusiasm. The ground is very fertile for quality assurance and there is a great potential for improvement of care in such an atmosphere of eagerness and conceptual understanding.

Despite some shortcomings and delays that have occurred within components of the project and delays in starting implementation of some activities, these have not irretrievably impeded the progress of the project. If the recommendations in the midterm evaluation report are followed, it is probable that the project will meet expected outputs at the end of the project in 1998.

EXECUTIVE SUMMARY

This is a midterm evaluation report of the Family Health Services (FHS) Project. FHS is a US$7 million, eight-year (August 1990-September 1998) project with Jordan's Ministry of Health. The purpose of the project is to increase the quality and cost efficiency of broad-based primary health care services in the public sector and to utilize private-sector health care providers more effectively in achieving national goals.

The project was modified from its original design for several reasons, including changes in the Government of Jordan's policies, changes in the strategic objectives of USAID/Jordan, and the World Bank's interest in restructuring the Jordanian health sector, particularly health care financing. Currently, the project has two major components. The first one, the Family Health Services Delivery component, includes quality assurance and family planning activities and the Family Medicine Specialty training program. The second component provides assistance to nongovernmental organizations. These include the National Population Commission (NPC) and the Jordan Association for Family Planning and Protection (JAFPP).
The largest activity under the project, Family Health Services Delivery, is administered by the Planning and Projects Management (PPM) and the Monitoring and Quality Control (MQC) Directorates in the Ministry of Health (MOH). The University Research Corporation (URC) of the Center for Human Services provides technical assistance through a Cooperative Agreement. The family medicine specialty training program and continuing education for the MOH is administered by the University of Jordan (UOJ), the Jordan University of Science and Technology (JUST), and the MOH, with technical assistance provided by the Brown University School of Medicine through a Cooperative Agreement. Under the nongovernmental organization component, Pathfinder International provides technical assistance to the Jordan Association for Family Planning and Protection, and the National Population Commission has a direct grant from USAID/Jordan. Technical assistance will be provided to the NPC by a resident information, education, and communications advisor from the Johns Hopkins University Population Communication Services.

The project is generally on schedule and its implementation is progressing as expected. Despite some shortcomings and delays that have occurred within components of the project and delays in starting implementation of some activities, these have not irretrievably impeded the progress of the project. If the recommendations stated in this report are followed, the project will reach the desired end of project status (EOPS) and assist USAID/Jordan in achieving its Strategic Objective of "Increased Practice of Family Planning with an Emphasis on Modern Methods."

Family Health Services Delivery Component

Family Health Services/Family Planning

The objectives of this activity are 1) to expand and improve the accessibility and quality of those family health services that most directly impact on maternal and child health and fertility, and 2) to assist the Government of Jordan in designing, developing, and implementing a comprehensive and integrated quality assurance (QA) program at all levels and ultimately to all facilities.

The evaluation team identified several issues that need attention if the project is to reach its objectives. The team made recommendations for strengthening and enhancing the Monitoring and Quality Control Directorate, enhancing its ability to assess training and to adapt future training programs to these assessments, and mobilizing efforts to expand the program to other governorates.

The MQC Directorate within the Ministry of Health is expected to assume full responsibility for directing and monitoring QA activities once the project ends. This unit has received training and technical assistance; however, more effort is needed to improve its capabilities. This effort should include clarifying its role and relationship to other directorates within the MOH and intensifying technical assistance.

In the Balqa Governorate, where the pilot quality assurance model hospital and Maternal Child Health/Family Planning (MCH/FP) Center were started, it is apparent that the QA concept has been embraced with enthusiasm at the hospital and the primary care levels. The ground is very fertile for QA in all governorates, and there is great potential for improvement of care in such an atmosphere of enthusiasm and conceptual understanding.

In the last year, the FHS project has started to expand beyond the pilot project in Balqa to two other governorates. To assist in meeting the new USAID/Jordan strategic objective of increased practice of family planning with an emphasis on modern methods, the team recommends that, as the expansion occurs, MCH/FP centers and birth spacing should be given priority attention and hospitals should be given less emphasis.

Quality assurance is a concept that Jordanians have embraced. To ensure that the concept is institutionalized, technical assistance needs to be provided until the end of the project. It is reasonable to assume that five years of continuous technical assistance may be necessary to establish a national program of this size.

Family Medicine Specialty Training Program

The purpose of this component is to establish new training programs in the University of Jordan

and the Jordan University of Science and Technology and to strengthen MOH's continuing medical education training in this specialty. This would create a new cadre of certified family medicine practitioners in Jordan to work mainly in the public sector.

This component has several potentially serious problems that need to be resolved by both UOJ and JUST and the technical assistance contractor, Brown University. First, the curriculum and training program currently being used at both UOJ and JUST are not in compliance with the accreditation standards set by the Jordan Medical Council (JMC). The concern is that current and future family medicine specialty residents may not be certified by JMC as family medicine practitioners in Jordan. Second, UOJ and JUST do not have adequate family medicine faculty. Sponsoring newly graduated doctors to be trained in family medicine in the United States has failed. Alternatives need to be found immediately.

If the above problems with the family medicine training program are not resolved satisfactorily by July 1, 1996, the start of the new academic year, USAID/Jordan should consider moving the program to the MOH or other appropriate solutions.

Nongovernmental Organizations

The Jordan Association for Family Planning and Protection component is on schedule. The five authorized new clinics are open and functioning. The other quality of care activities are progressing and there are no serious problems.

The National Population Commission grant was signed in May 1995. The proposed activities under the grant will be mainly institution building and the implementation of a mass media campaign complemented by advocacy activities. There are no problems with this component.

LIST OF RECOMMENDATIONS

1. Continued and expanded support for quality assurance should be at the highest level within the Ministry of Health. (p.18)

2. A permanent steering committee at the MOH Secretary and/or the Undersecretary level should be formed to obtain a wider base of support for QA both technically and administratively. The members of this committee might include the PPM Directorate, the MQC Directorate, the Primary Health Care Directorate, the Maternal and Child Health Directorate, the Information Center, two or three governorate representatives on a rotating basis, and the current technical assistance contractor, if appropriate. (p.18)

3. The role and responsibilities of the MQC Directorate should be clarified as the focal point for receipt of quality assurance resources, including technical assistance by both the TA contractor and the MOH. The MQC Directorate should be the lead directorate in all areas of implementation, including the contact point for governorate programs. To assume its expected role in leadership, monitoring, and training, the capabilities of the MQC Directorate staff should be enhanced, and more staff should be added as the project expands. (p.18)

4. The MQC Directorate's inspection role that is not related to quality assurance should be moved to a separate unit within the directorate. (p.18)

5. Weekly meetings should be held among the directors of PPM, MQC, and URC to strengthen communications. These meetings could be the forum for the parties to discuss technical issues relating to quality assurance activities and to share information. The MQC Directorate should schedule these meetings. The line of communications by the TA contractor should follow the usual MOH lines of authority. (p.18)

6. The role of the PPM Directorate should be clarified as one of administration, as it is with other USAID projects, and not one of direct implementation. (p.19)

7. The URC role should be clarified as one of providing technical assistance to the MQC Directorate to assist and enhance its ability to assume full responsibility for the QA program. (p.19)

8. URC should encourage and assist the MQC Directorate in documenting quality assurance, cost reduction, and family planning studies in the Balqa Governorate and other governorates as the project expands. (p.19)

9. An external assessment of all family health services/family planning training should be conducted. The project is expanding to other governorates, and the training is an

important component of the expansion. More attention should be given to evaluating workshops and the impact of training, such as before and after comprehension tests. (p.19)

10. URC should improve its data generation, retrieval, and presentation to ensure clarity, uniformity, and better organization. (p.19)

11. Further technical assistance should be provided to the Perinatal/Neonatal Mortality Study to complete statistical handling of the data. (p.19)

12. The Causes of Death, the Maternal Mortality, and the Morbidity and Health Situation Studies will not be completed by September 1996, the end of the URC extension. If it is desirable to have these studies finished as expected, it is recommended that additional technical assistance be provided. (p.19)

13. The project should continue to emphasize the expansion of QA/FP to other governorates, with reduced support to the Balqa Governorate. During the expansion phase, greater emphasis should be given to MCH/FP centers rather than to hospitals. (p.19)

14. Family planning should be given greater emphasis in the further expansion of QA/FP in other governorates. (p.19)

15. The MOH should use Commodity Import Program funds to renovate the necessary MCH centers to expand the QA/FP component to other governorates. USAID should provide funds for technical assistance and to equip the centers. (p.19)

16. In all improvement studies relating to MCH and family planning services, when possible and appropriate, emphasis should be given to reducing costs as part of improving quality. (p.19)

17. Long-term technical assistance to the quality assurance program, with emphasis on the integration of family planning into MCH service activities, should be provided until the FHS project ends in 1998. (p.20)

18. Brown University, UOJ, and JUST should act immediately to bring UOJ and JUST into compliance with the Jordan Medical Council certification requirements for family medicine residents. If the issue of accreditation is not solved by July 1, 1996, USAID should give serious consideration to moving the entire program to the MOH or other appropriate solutions. (p.29)

19. Brown University, UOJ, and JUST should address the issue of inadequate exposure of family medicine residents to the technical and philosophical aspects of clinical management for independent decision making. This is important for residents' future practice.

Formation of a family medicine department in each institution would contribute to a resolution of this issue. (p.30)

20. Brown University, UOJ, and JUST should consider a more appropriate way to secure faculty for the family medicine specialty as the current method of sending residents to the United States is not working. (p.30)

21. The MOH should be more actively involved in recruitment and should ultimately support eminently qualified residents for the family medicine program. If the MOH recruitment fails, the objective of training family medicine physicians to work in primary health care centers may not be reached as the university recruited residents may go into private practice. (p.30)

22. Brown University, UOJ, and JUST should ensure that adequate training in family planning services is included in the family medicine program. (p.30)

23. UOJ and JUST should confer with Brown University to assess the program evaluation instruments and to ensure that they conform to family medicine educational requirements. (p.30)

24. Before expanding the current clinic management information system to all JAFPP clinics, Pathfinder and JAFPP should obtain technical assistance to review and assess the current CMIS system to determine if it can fulfill the needs and expectations of JAFPP and to determine if the current system is too complicated for the requirements of JAFPP. The option of obtaining local service support should be reviewed at the same time. (p.35)

25. Pathfinder should continue to assist JAFPP to conduct before and after clinical improvement studies to measure impact of quality of care improvements. (p.35)

26. NPC should be encouraged to develop a system to document its accomplishments and its impact. (p.38)

27. The plan to hire a full-time IEC advisor for the NPC component is an excellent idea and should be pursued. (p.38)

1. INTRODUCTION

1.1 Project Description

This report documents the midterm evaluation of the Family Health Services (FHS) Project, a bilateral agreement between the Government of Jordan (GOJ) and the United States Agency for International Development (USAID). The eight-year, US$7 million project was authorized on August 28, 1990. All the funds for the project are obligated. The project completion date is September 30, 1998.

The goal of the project is to reduce infant mortality by 15 percent and maternal mortality by 20 percent and to reduce the rate of growth of recurrent cost financing needs within the public sector. The purpose of the project is to increase the quality and cost efficiency of the primary health care services provided in the public sector and to utilize private sector health care providers more effectively to achieve national family health care goals.

The FHS project was designed and developed in 1990 with four components: 1) Health Planning Analyses; 2) Health Financing Interventions; 3) Family Health Services; and 4) Support to the General Secretariat of the National Population Commission. Although the project was authorized in August 1990, the signing of the Project Agreement with the GOJ was delayed until September 1991 due to the Gulf War.

The project was modified in August 1991 because of the delay and because of important changes in the government's health care policies. The project was modified to have two phases. Phase I, essentially a preparatory phase, was to be devoted to completing the necessary health studies, and testing and developing alternative health care financing and service delivery strategies. Phase II was to be the implementation phase.

In 1993 the World Bank and the GOJ signed a US$20 million health sector loan that included substantial funding for improving the hospital sector and for studies relating to hospital management, health care financing, and health sector policy. Because of the World Bank loan and at the request of the Ministry of Health, the Mission dropped Phase I relating to health care financing and health planning, which duplicated the World Bank efforts.

In late 1992 at the same time of the World Bank loan negotiations, USAID/Jordan adopted "fertility reduction" as one of its strategic objectives. Due to these two changes the Mission concentrated on the Family Health Services component of the project. The component was expanded by integrating birth spacing and family planning services while improving the quality of family health services of government health centers and clinics. To implement this component, the Mission did an add-on to the centrally funded Quality Assurance Project. A Cooperative Agreement (CA) with the University Research Corporation (URC) was signed in December 1993

after a delay of one year in the USAID/Washington contract's office. The CA with URC ends in March 1996.

The family medicine specialty training program was started in August 1993 with a Cooperative Agreement (August 1993-June 1997) with Brown University. This program was in the Project Paper and the only change was that the program is now in two universities, the University of Jordan (UOJ) and the Jordan University of Science and Technology (JUST) rather than in the Ministry of Health (MOH). Under the Cooperative Agreement the MOH is expected to receive assistance in training physicians in primary health care and family medicine.

The Jordan Association for Family Planning and Protection (JAFPP) receives technical assistance and support from Pathfinder International through a five-year Cooperative Agreement (June 1992-June 1997) with USAID/Jordan. The National Population Commission has a grant from USAID/Jordan (May 1995-September 1998).

1.2 Evaluation Methodology

The Scope of Work (Appendix A) identifies the objectives of the evaluation:

- Determine the status of the project in relation to its purpose
- Identify accomplishments and problems and make specific recommendations for action to the Mission
- Determine the conformance of the project with the Mission's Strategic Objective, "Increased Practice of Modern Family Planning Methods"
- Determine the extent to which the project, as currently structured and implemented, is or is not contributing to the achievement of this objective

The evaluation team included three members. Ms. Charlotte Cromer (U.S. citizen) served as the family planning program specialist and as team leader. Dr. James Hudson (U.S. citizen) served as the quality assurance specialist. Dr. Saher Shuqaidef (Jordanian) served as the primary health care/hospital service delivery specialist. Fieldwork was carried out in Jordan for one month, January 20-February 20, 1996.

The team used several methods of data collection and analysis. A comprehensive document review was carried out (see Appendix B). Interviews were conducted with respondents from the MOH, JAFPP, Pathfinder, Brown University, University of Jordan, Jordan University of Science and Technology, the National Population Commission, USAID, and the University Research Corporation (see Appendix C). Site visits were conducted to four governorates: Amman, Balqa, Irbid and Madaba.

The team also analyzed service statistics, evaluation reports, training statistics, and budgetary

data. Finally, additional input was sought from implementing organizations. Debriefings were held during the final week with USAID and MOH staff during which key findings and recommendations were discussed.

2. FAMILY HEALTH SERVICES/QUALITY ASSURANCE COMPONENT

2.1 Introduction

The formulation of a quality assurance (QA) component as part of the proposed FHS project coincided with the conduct of the First National Symposium on Quality Assurance in Amman in June 1992 with joint participation by the MOH and the Center for Human Services/University Research Corporation. The symposium, sponsored by USAID, stimulated further interest in exploring ways to improve quality while lowering health care costs. This interest led to a joint effort between the MOH and URC, also sponsored by USAID, to conduct a regional quality assessment study. The results of this study focused on structure and process through staff surveys and on outcome through client interviews. The study involved one hospital and five health clinics in Balqa, and the results were presented to key MOH officials in a November 1992 workshop. At this meeting, plans were developed for implementation of a pilot program of quality assurance in the primary and secondary care facilities of the Balqa Governorate (Salt), and for a Steering Committee within the MOH to plan for the implementation of a national QA program.

Shortly thereafter, an agreement was reached between USAID and the MOH wherein USAID would contract with URC to provide continuous technical assistance for the implementation of a comprehensive nationwide quality assurance program. The objective was to enhance the quality of health services, contribute to the reduction of health care costs and the reduction of infant and maternal mortality through improved family health services.

The completion of this Cooperative Agreement was delayed for twelve months at USAID's central Contracts Office; and it was not until November 1993 that the agreement was finally signed in Washington, DC.

The agreement extended the quality assurance aspect of the contract to include providing better family planning services in order to better assure their acceptance, affordability, and safety.

This CA of December 1993 contains an "Implementation Plan to Strengthen the Quality of Family Health and Family Planning Services and to Support an Integrated Quality Assurance Program in the Ministry of Health in Jordan." Five strategies for reaching the goals and objectives of the plan are listed, and a number of outcomes expected to be reached by the end of 1995 (later extended to March 1996) were included. Some are quantifiable, others more descriptive. This evaluation addresses each of the strategies in turn, with reference to expected outcomes when appropriate.

It should be noted that over the past two years the project has been hampered by turn-over of key staff. The first resident advisor (RA) under the auspices of URC, A.E. Al-Assaf, M.D., CQA, arrived in February 1994, and implementation of the agreement began in May 1994. Dr. Al-Assaf

left the project in January 1995, and was replaced by an interim RA, Jolee Reinke, MSN, CPHQ. In August 1995, Ms. Reinke was replaced by the third RA, Walid Abubaker, M.D. During this period, the MOH also experienced changes at the highest administrative levels (the Minister and the Secretary General), although these changes were not as critical to the project as the contractor RA replacements.

2.2 Strategy A: Assist the MOH in developing the capacity of a central QA unit to ensure that the health care resources in Jordan are used to improve the quality and efficiency of care continuously.

In the overall design of a national QA program, the central unit would assume responsibility for development of national QA policies and procedures, development and review of standards of care, and input into a nationwide system for collecting, managing, and analyzing data relating to quality of care. The central unit will take the lead in implementing a system to monitor quality of care and support services. It will act to identify priority quality problems in the health system nationally. It also has a number of extensive educational responsibilities, including the initial training of regional and local QA teams, the implementation of an effective training of trainers (TOT) program to meet the needs of an expansion of the effort into all twelve governorates, and the organization of an effective in-service training and continuing education program for service staff.

To reach a level of technical competence and administrative development within the central unit in order to effectively assume these responsibilities and authority to carry them forward, it was planned that a number of technical assistance activities be provided by URC through the resident advisor to the unit.

2.2.1 Expected Status, by March 1996

- For central Unit staff, the following workshops would have been completed:

  Training in basic QA skills, 10 staff
  Training in advanced QA skills, 5 staff
  Three training of trainers courses for central unit staff

- Selected central unit staff would have received training in the U.S. on fundamentals of QA in one-week to three-month courses.

- A national information system for tracking quality of care would be developed and implemented.

2.2.2 Status/Accomplishments

The MOH took the initiative to establish a central unit, the Monitoring and Quality Control (MQC) Directorate, in March 1993 following planning meetings, and well before the signing of the Project Agreement and the arrival of the RA. A director was appointed and staff recruited. Subsequently, a Quality Council was formed to function as an executive body for the planning of the monitoring of health services. The functions of the Directorate were established as the following: setting standards for maternal and child health (MCH) and family planning (FP) services, monitoring care on a national basis, and providing technical assistance (TA) on quality improvement to various hospitals and clinics in the MOH. At this date, the MQC Directorate is working to set standards of care but has not reached its capacity to monitor care on a national, or even regional, basis.

Activities within the unit have resulted in the generation of a list of national standards and indicators for ongoing monitoring of health care services at the clinic and hospital level. Over 100 job descriptions for MOH staff and local Family Health Center (FHC) staff have been generated. These, however, are in various stages of approval and final sign-off by different authorities within the MOH.

MQC staff have attended a number of workshops designed to generate and enhance their competency in the roles they are expected to play in carrying out the responsibilities of the central unit. Fourteen have been trained in QA awareness, 12 in basic QA, seven in intermediate QA, 12 in team building, eight in customer service, five in standards setting, and six have received TOT workshop training. Some members of the unit were sent to the U.S. for study tours of QA programs.

2.2.3 Problems

Some confusion or ambiguity exists over the role, function, authority, and responsibility for QA programs vis-a-vis the MQC Directorate and the Planning and Projects Management (PPM) Directorate. The confusion has seriously interfered with communications at the top administrative levels. The problem has created a number of situations where planning and action in the field has taken place with little information relayed back to the central unit; and subsequently little guidance is sent back to the field. Field personnel state that they are often uncertain as to which administrative unit they should send reports and action requests. This has often caused delays in routing and getting approval on such items as standards and even job descriptions for clinic personnel. This problem has also delayed the development of the capacity within the central unit to assume a lead role in the expansion of the project to other governorates and to effectively direct training efforts.

The confusion regarding the role of the MQC and PPM Directorates results from the fact that PPM is the directorate in the MOH that is responsible for all USAID projects and as such has a monitoring and oversight role. Thus PPM's role overlaps with the monitoring and quality control role of MQC.

Whereas the training episodes have met the expected levels, and key members did receive experience in the U.S., it is the opinion of many in the MOH and, indeed, the staff of the MQC, that much more training and hands-on technical assistance to the MQC will be necessary over a prolonged period of time to assure complete competence in carrying out their proposed responsibilities of directing a national QA program when TA has been concluded.

Members of the MQC Directorate have expressed concern on several occasions over what they consider shortages of supplies and computer technology to carry out their functions effectively.

A national information monitoring system on quality of health services is far from a reality at the present. This is due more to lack of technical experience and expertise in this complex field than to lack of computer capability.

In spite of much effort at the MQC Directorate level to develop and oversee the creation and use of a large number of protocols and guidelines for high-quality clinical and administrative practices, there has been little progress made in developing a comprehensive clinical management system that can be used to monitor quality of care. This is a complex undertaking that will require far more technical assistance than has been provided so far.

During the early months of development and implementation of the MQC Directorate, staff members spent an inordinate amount of time designing inspection protocols for hospitals and clinics as part of the duties originally assigned to the Directorate by the MOH. This inspection role, somewhat different from the major quality improvement activities, has deterred staff from concentrating on methods to secure cooperation with health service workers on improvement strategies.

2.3 Strategy B: Assist the MOH in designing, implementing, and evaluating a pilot QA program in the Salt Health Directorate and Hospital.

The Balqa Governorate was chosen as the site of a pilot project to develop a new regional model for decentralizing health services in Jordan and for introducing a number of administrative reforms. Under this strategy, QA activities would be introduced for family health including family planning services and in-hospital services. The lessons learned from experience in this pilot project are to be introduced into other regions. This pilot project is to include at least one hospital, a model comprehensive health care facility, and one or more primary health clinics. Protocols are to be developed to assure appropriate referral systems between the primary and secondary systems for general health care services and for maternal predelivery and postdelivery care in particular.

The implementation plan describes a number of TA activities to be carried out by URC in assisting the MOH in achieving the objective of establishing this pilot project and some of the activities to be expected in the clinical facilities.

2.3.1 Expectations, by March 1996

- The MQC Directorate was to have developed 20 curricula and courses to improve clinical family health services in the pilot area.
- The MQC Directorate was to have provided 15 training of trainers courses for the pilot area staff.
- The MQC Directorate was to have developed and implemented a monitoring system for quality and outcomes of care in the pilot area.
- The pilot area QA program elements will have been established in the hospital and clinics; and the committees and councils necessary to assure their functioning will have been established.
- At least 30 quality improvement efforts will have been completed in health clinic facilities and another 30 similar studies completed in hospital-based maternal and child services.
- Protocols were to have been developed to assure an appropriate referral system between the primary and secondary systems for general health care services and for maternal predelivery and postdelivery care in particular.

2.3.2 Status/Accomplishments

The pilot project in Balqa Governorate was initiated in 1993. The first element was the establishment of a QA unit at the Al-Hussein Hospital. Shortly thereafter, QA activities were began formally at four primary and comprehensive centers. One of the comprehensive centers in the pilot project was designated to become a model health center in February 1995 and was equipped and established as such in May 1995. As a result of this renovation, equipping and transformation, patient loads increased considerably in this center from May 1995 on, almost doubling henceforth. The number of people seeking family planning services at this center almost doubled per month after May 1995. However, general health services did likewise, so the proportion of family planning services to MCH/FHS remained about constant, at 18-21 percent of services. Since figures on the size of the eligible population in the region are not available, there are no use rate data available, nor can we know how many of the clients who may have been new to the model center were former regular users of other clinics. Nevertheless, the new model center is impressive, and it is encouraging that many women are attracted to it for family planning services.

In early 1993 a Quality Coordinator was selected at the Governorate General Directorate for Health level and trained in QA concepts/methods. A Quality Council was formed at this level, and it has organized several quality improvement teams to evaluate administrative and clinical health services in the Governorate. Clinical guidelines for nursing care in the entire area has emerged from this activity. The Quality Council has, with the help of the MQC Directorate, developed 30 structure and process guidelines for primary ambulatory-based care; identified some outcomes of care standards to be used in assessing and monitoring primary health care in the Governorate. This council has been instrumental in establishing Quality Councils at a comprehensive health clinic in Ma'adi.

Although protocols have been developed relating to the incorporation of a functioning referral system, the final approval of many protocols, including these, has been delayed at the MOH central level.

A referral system incorporating the Comprehensive Postpartum (CPP) component of the project awaits the establishment of CPP units in key hospitals. Once this system is in place, it will involve not only referral systems back and forth between model primary centers and the hospital, but also between all FHS clinics in the region and the hospital. Such a system will require close coordination between the Family Health Services Project and the Primary Health Care Directorate in the MOH.

At the Balqa Health Directorate level, a level below the General Directorate for Health, a similar Quality Council has been established and a Quality Coordinator has been appointed. This unit has developed 20 clinical standards and several administrative procedure protocols. The Directorate has exercised oversight on the QA activities of the primary health clinics in Balqa, including staff job descriptions, effective use of nurses, effective use of transportation to improve home health visits, and immunizations.

At Al-Hussein Hospital in Salt, a QA program has been initiated and involves several ongoing hospital committees. A Quality Council has been organized at the hospital which has taken on the function of setting priorities, designing strategies for improvement interventions and monitoring quality of care throughout the facility. Of particular note are improvements in medical record retrieval, both in the out-patient clinic and the hospital itself. Studies resulting in cost savings have been reported. These include a study that has led to the reduction of the inappropriate use of xylocaine gel tubes leading to an estimated savings of US$3,477 in 1995, and a study that has led to the reduction of inappropriate antibiotic use for infections resulting in an estimated annual savings of $35,000. The evaluation team reviewed summary pages of the first study, but information on the other study was not available.

2.3.3 Problems

Whereas extensive QA activities have been introduced at both the Al-Hussein and Shunah Hospitals and at four primary care clinics and one model health center, and whereas three Quality Councils have been established and staffed, the documentation of before and after conditions relating to improvement interventions has been spotty at the sites of implementation (hospitals and clinics), at the MQC Directorate, and at the URC office.

It is apparent that the QA concept has been embraced with enthusiasm at both the hospital and the primary care levels. The ground is very fertile for such activity in all governorates, and there is a great potential for improvement in care in such an atmosphere of enthusiasm and conceptual understanding. Good documentation of successes will be very important in sustaining this enthusiasm.

2.4 Strategy C: Assist the MOH to expand and integrate quality birth spacing services into ongoing family health services.

In keeping with increasing demand from the population for such services, and to meet the objectives of the MOH, it is recognized that staff in MCH and PHC clinics need to be better trained in providing quality family health services. This part of the project involves preparing the MQC Directorate to develop standards and protocols for FHS; to provide TOT courses for MOH trainers and clinic service personnel; to assist regional training teams to provide training to midwives, nurses, and physicians; to complete the development of a national management information system to monitor family health and family planning services; and to continuously assess equipment and contraceptive needs.

2.4.1 Expectations, by March 1996

This strategy calls for an increased proportion of family planning services in FHS and MCH clinics through improvement in the quality, accessibility, and safety of these services. Progress toward this strategy could be measured by the number of training courses/workshops provided and by statistics on the changing proportion of family planning services provided in these clinics.

2.4.2 Status/Accomplishments

Records maintained in the URC office indicate that 510 individual health care workers and administrators, almost all from the Balqa Governorate, have participated in at least one workshop in either QA awareness or Family Planning Services Quality Improvement; and of these, 177 have participated in at least two workshops. Only 43 have attended three or more. In these figures, the ratio of QA awareness to Family Planning QA ran a little over three to one. Most of the participants who attended Family Planning QA workshops were from Balqa.

It has been somewhat difficult to assess the progress toward increasing the number of clinic service workers who are fully trained in QA or in family planning QA since there is not a good working definition of what constitutes "fully trained." The project needs to create a working definition now to assist in management decisions and for the final evaluation.

Eleven health care workers from Balqa participated in TOT workshops in family planning QA. A number of TOT workshops for FP QA are scheduled for other governorates in 1996 as the project expands.

As described in section 2.3.2, the one established model center in Salt experienced a large (almost 100 percent) increase in family planning services as soon as it was refurnished and renovated. However, it also began, at the same time, to experience a similar increase in general clinical services demand. In addition, it was impossible to determine how many of the new family planning clients were drawn from regular use of other clinics.

The January 19, 1996, draft Quarterly Report from URC describes a survey of 35 clients of the model center in Salt about their knowledge of breast and cervical cancer screening, family planning, sexually transmitted disease, and appointment follow-up. The results revealed poor knowledge in these areas, indicating the need for better instruction of the clinical staff on these topics. This information prompted the initiation of three staff workshops and intensive counseling/training of the staff. A repeat survey of clinic clients will be conducted in six months after the extensive staff training and the results will be compared.
During the last quarter of 1995, the following training programs were completed in the model center:

Medical counseling 8 participants
Customer services 15 participants
QA awareness 20 participants
Infection control 9 participants
Depo-Provera 11 participants

2.4.3 Problems

The concept of increasing and improving family planning services appears to be well understood, and steps are being taken at the MQC Directorate level as well as in the field to meet this objective. It appears, however, that most of the actions have been initiated in the field and that the MQC Directorate has been relatively less involved. The MCH Directorate in the Ministry of Health needs to be more actively involved in this process, and the MQC Directorate needs to be given assistance in taking the lead to direct this activity. Better documentation about improvements needs to be put in place as they occur.

The program is encouraged to continue to expand beyond the Balqa Governorate to incorporate additional model comprehensive centers that feature quality FP services. The MQC Directorate needs assistance in taking a more active role in documenting efforts and in the implementation of program expansion beyond Balqa.

2.5 Strategy D: Carry out studies to assist the MOH in its strategic planning, to document unit costs, and to evaluate the changes in efficiency resulting from QA activities.

Five studies are under way. The general purpose of these studies is to establish objective baseline information against which the impact of this entire package of health care quality improvement initiatives might be measured eventually. These studies address perinatal/neonatal mortality rates, maternal mortality rates, a cross-sectional analysis of overall morbidity and of risk factors associated with a leading cause of morbidity and mortality, i.e., cardiovascular disease, an analysis of causes of death in the general population, and a calculation of unit costs associated with in-patient hospital care and clinic visits.

2.5.1 Expected Status, by March 1996

The five studies are expected to be completed and two national seminars are to be held to review the results.

2.5.2 Status/Accomplishments

The perinatal/neonatal study involves the recording and assessment of cause of death of neonates using information from twelve hospitals, which comprises about half of the deliveries per year in Jordan. This study has gone further along than any of the other studies. Fieldwork and data entry have been completed. In the final analysis phase, some technical concern may emerge over the degree to which infants born at home (approximately 15 percent of all live births) in the regions included in the sample are likely to be brought to a hospital in the sample region for care of life-threatening conditions during the neonatal period. Discussions with the principal investigator indicate a desire or need for some additional statistical assistance in handling the data.

The causes of death survey is a very ambitious study that attempts to establish and classify the exact clinical cause of death on a stratified sample of the Jordanian population over a year. The design calls for collection of primary data from clinic or hospital records and or from extensive interviews of next of kin of persons who have died. There have been delays in recruiting and organizing the field staff and getting the data acquisition phase under way in the field. It is doubtful that this study can be completed before early 1997.

A maternal mortality study will attempt to determine the true maternal mortality rate in Jordan. Two sources of data will be tapped: hospitals and the Civil Registry. Presently, staff are in the field collecting data. More cases are presently needed for statistical purposes. It is estimated that a final report of the study will be completed by November 1996. This may be possible, but this timetable seems optimistic.

The morbidity study is the most ambitious of the four. New dimensions have been added since the original study design. A survey of a stratified sample of households in three regions of Jordan is planned. This survey will obtain detailed information on the health status of family members, and will entail a two week follow-up of any family member found to be ill until a definitive diagnosis can be made. In addition, an extensive interview, coupled with physical measurements, and laboratory measurements will be taken on family members to tabulate the presence of risk factors for cardiovascular disease. The second dimension of this study requires the tabulation, during four quarters of a year, of all the cases in a stratified sample of hospitals and clinics by diagnosis. Fieldwork is under way. The study is likely to be completed in mid-1997. Part of the study follows recommendations contained in an earlier World Bank study design, but this study entails household visits by physicians rather than lay reporters using standard questionnaires. This could lead to some inter-rater variability and thus some confounding of the data, ultimately leading to

further delay in the analysis.

A cost study is designed to calculate unit costs of hospital and clinic services. It could provide reference data on unit costs for use in subsequent improvement studies. To date, the study has involved the analysis of information from one hospital, and the unit costs are calculated on a clinical department basis (e.g., Department of Surgery, Department of Medicine) with no break-down by procedure or clinical diagnosis. The ambulatory side of this study is to involve the analysis from five clinics of varying size and function, with results being calculated as the average cost per visit. However, because of the lack of clinical detail in the units used, (e.g., diagnosis or procedure on the hospital side; reason for visit on the ambulatory side), the lack of inclusion of bed occupancy rates on the hospital side and seasonal variation on the ambulatory side, the resultant costs, as currently constituted, may be of limited value. Because of scheduling problems beyond its control, the evaluation team was unable to meet with the principal investigator of this study to confirm the validity of these concerns.

2.5.3 Problems

All of the studies are behind schedule. URC has increased its consultative efforts with Dr. Matthew Tayback of the Johns Hopkins Medical Institutions to improve the process. Bi-weekly telephone conference calls have been scheduled. More on-site technical assistance may be necessary.

Because of the absence of details on diagnosis or procedure on the hospital side and reason for visits on the clinic services side, the cost study may be of limited usefulness.

2.6 Strategy E: Assist the MOH in expanding improvements in family health service and the QA program to other regions of the country.

The MOH is anxious to apply lessons learned and techniques developed in the original Balqa Governorate pilot project to other regions of the country. It was planned that this expansion would take place during 1995 and 1996 through efforts of regional training teams, by close collaboration with the Primary Health Directorate of the MOH, and through deliberate expansion of the national QA program. Expansion of the QA program would be coordinated by the MQC Directorate with technical assistance from URC.

2.6.1 Expectations, by March 1996

- The MQC Directorate would have developed 100 clinical standards, protocols, and guidelines relating to the provision of family health and family planning services, to be used in expanding the pilot project into all governorates.

- MQC would have developed and implemented a national information system for tracking quality of care.

- Model FHS and FP clinics would have been established in five governorates in addition to Balqa.

- Up to 500 clinic personnel, half of them women, would have been trained in improved family health and family planning services.

2.6.2 Status/Accomplishments

The MQC Directorate was active over the year in overseeing the development of clinical and administrative protocols and guidelines and in overseeing training workshops. Analysis of records in the URC files reveals that over 500 clinic personnel have attended at least one workshop in either QA awareness or improved FP services. The files contain a number of protocols and guidelines that address a large variety of clinical topics for physician and nursing services.

The Madaba General Health Directorate and Hospital were chosen by the Minister of Health in 1995 for the first expansion sites beyond the Balqa Governorate. A QA project-trained pharmacist was selected to serve as QA Liaison Officer for Madaba. Meetings have taken place between the hospital administrator and the Governorate General Health Director, and a preliminary strategy for implementing QA in the hospital has been developed. Hospital QA Committee members have been identified.

A Quality Improvement Council has been established for Madaba, and a clinic has been identified to become a model health center.

Quality assessments have been completed in four clinic sites, and a patient satisfaction survey has been conducted. The Madaba Governorate has established a Quality Assurance Steering Committee similar to that established in Balqa. The first QA awareness workshop attracted 43 trainees, half of whom were physicians.

Irbid has been identified as the site of the next expansion and establishment of a model health center.

QA awareness and FHS improvement workshops have been conducted in Ma'an, Jarash, Ajloun, Mafraq, and Amman in addition to those in Madaba and Irbid.

QA Coordinators have been chosen and partially trained in eight governorates.

A review of the assessment of training courses through a random reading of the questionnaires returned by trainees reveals generally high marks for the course content and method of

presentation of the QA awareness workshops and the intermediate QA skills course. Any negative comments were generally about the lack of adequate time to present the extensive material. Comments on the success of understanding or grasping the content were less favorable for the TOT workshop, which contained more complex material than the QA awareness sessions. It is of interest to note that apparently over 90 percent of the trainees return the evaluation questionnaire.

2.6.3 Problems

In spite of all the organizational efforts in Madaba, there is still no established model health center. Negotiations over the rental of a clinic site for this development have remained at a standstill for months, with no resolution in sight.

Personnel representing the QA Councils in Madaba have expressed frustration over having to deal with two separate administrative channels within the MOH. It remains unclear whether they need to route requests through the PPM Directorate or through the MQC Directorate. This causes much unnecessary delay in even minor requests.

2.7 Appropriateness of Indicators

Many of the expected end of project status accomplishments in the CA were stated in quantifiable terms, and this facilitated an objective assessment by the evaluation team. For the remainder of the project period, the team strongly suggests that Implementation Plans related to future CAs should contain quantifiable end of project status measures where possible.

2.8 Institutional Performance

It should be understood that, whereas the QA component of this project has been granted an extension until March 1996 to complete work outlined in the Implementation Plan of December 1993, this midterm evaluation is essentially assessing the accomplishments of a three year project compressed into two years because of the one year delay in the buy-in with URC.

2.8.1 University Research Corporation (URC)

Turnover in key personnel (three resident advisors in a period of two years) hampered the continuity and consistency of the technical assistance.

There have been reports of strained relationships between the present RA and counterparts within the MOH. Discussions with key participants during the evaluation indicated to the team that these

relationships are improving, and that administrative changes are being put into place to assure these improvements.

The URC needs to concentrate more attention on the MQC Directorate, on documentation of project accomplishments, and on the QA/FP and QA/FHS training efforts. This is particularly important as the project expands to other governorates. If the URC needs additional staff or short-term TA for this, USAID/Jordan is encouraged to provide it.

2.8.2 The Ministry of Health (MOH)

Confusion and ambiguity over the role, function, authority, and responsibility for QA programs vis-a-vis the MQC Directorate and the PPM Directorate has slowed the development of a fully functional central QA unit, and has contributed to delays in getting programs established in the field.

Subsequent delay in implementation of a fully functional central QA unit has delayed training programs and expansion of the project into other governorates.

Despite the shortcomings of both institutions that are enumerated above, the overall performance of both has been acceptable, given the constraints of the project. The delays have not irretrievably impeded the progress of the project in ultimately reaching stated objectives. If recommendations stated in this report are followed, the project will very likely reach the expected status by the end of 1998.

2.9 Effectiveness of Technical Assistance and Training

Since the expansion of the project into other regions of the country beyond the Balqa Governorate will depend so heavily upon solid training, especially that related to the TOT effort, this part of the QA component needs better evaluation and more technical assistance than has heretofore been provided.

If recommendations contained in this report are carried out, these training issues can be satisfactorily addressed by September 1996.

2.10 Lessons Learned

Although the ground is fertile in Jordan for the development and incorporation of a successful system of health care quality improvement (i.e., strong interest and enthusiasm and high comprehension and understanding of the principles and theory), it is, nevertheless, unreasonable to expect to find more than two or three organizations (hospitals or clinics) practicing truly effective quality improvement programs even after two years of continuous technical assistance. Likewise, it will take more than two years of technical assistance to establish a strong central unit for a national program. The development and institutionalization of a highly organized system for measuring before and after interventions only comes after some experience with the concepts; and a truly useful management information system for monitoring care and for clinical and managerial decision making is rare even in the most sophisticated national programs. The nationwide system of quality assurance in the private sector hospitals in the Netherlands had only two to three hospital staffs practicing solid QA programs after two years of effort, and it took five years of constant effort to move the program nationally. The same time period was experienced by the hospitals under the Ministry of Health in Malaysia a decade later. At this point in development, it might be more useful for selected members of the MQC Directorate to visit the CBO, Utrecht, the Netherlands or the MO, Kuala Lumpur, Malaysia, rather than hospital or ambulatory facilities in the U.S. In the U.S. many current competing systems have grown to such magnitude and complexity that the resultant equipment and staffing needs generate administrative costs equal to the costs saved.

2.11 Conclusions

More effort needs to be applied to improving the capability of the MQC Directorate to assume its expected leadership role in directing and monitoring QA activities nationally. This effort should include clarifying MQC's relationship to the Planning and Project Management Directorate, the Primary Health Care Directorate, the Maternal and Child Health Directorate, and the Information Center. The effort should also include enhanced and continuous technical assistance in all matters of QA implementation nationwide and the further development of an effective information management system.

The time has come to make a major effort in establishing the model center in Madaba and to get on with the organization of an effective QA program in that center as well as throughout the governorate. This will require shifting emphasis from the Balqa Governorate.

Since the most effective means for improving family planning services is to improve the quality of services in the centers that provide such services, henceforth, the major emphasis in this project should be directed at clinic rather than hospital systems.

TOT programs will play an increasingly important role in expansion of the QA project to other governorates. Although before and after assessment of workshop satisfaction by attendees has been generally completed, the team found little evidence of a systematic compilation of the results. It has been difficult, therefore, to obtain a concise assessment of the adequacy of the training impact. Furthermore, there was little evidence of before and after measures of content competence. Some technical assistance in obtaining these evaluation measures are needed.

Technical assistance by the URC to the central unit (MQC Directorate) needs to be enhanced over the next few months in order to bring the unit in line with expectations in terms of original project design.

Training programs in QA awareness and theory can be expected to be developed to reach the expected numbers of health service workers, and the model centers can be equipped and remodelled in all twelve governorates by the end of the project in two years (September 1998). It will be important to have these model centers renovated and ready to participate in the functioning referral system relating to the nationwide CPP effort. However, it is unreasonable to expect that all twelve centers will be fully practicing quality assurance programs with before and after studies by that date. A more reasonable expectation is to have three centers with effective, fully functional QA activities by the end of 1996, eight by the end of 1997, twelve by the end of September 1998.

Technical assistance to the QA component of the project, therefore, needs to be continued

through the end of the project (September 1998) with emphasis on improving the capabilities of the central unit (MQC Directorate) and in the model centers in the governorates. It is important that indicators relating to progress in the activity over the next two years be written in quantifiable terms.

Since a prominent objective of this entire project is to induce a number of quality improvements leading eventually to a nationwide reduction in costs of care through more appropriate utilization of health services, it is urgent that the project emphasize a series of local studies aimed at improving quality and that these studies contain quantifiable data of before and after interventions.

The perinatal/neonatal and maternal mortality studies, the national cause-of-death study, the morbidity study, and the cost studies are all in need of more technical assistance to speed their conclusion.

2.12 Recommendations

1. Continued and expanded support for quality assurance should be at the highest level within the Ministry of Health.

2. A permanent steering committee at the MOH Secretary and/or the Undersecretary level should be formed to obtain a wider base of support for QA both technically and administratively. The members of this committee might include the PPM Directorate, the MQC Directorate, the Primary Health Care Directorate, the Maternal and Child Health Directorate, the Information Center, two or three governorate representatives on a rotating basis, and the current technical assistance contractor, if appropriate.

3. The role and responsibilities of the MQC Directorate should be clarified as the focal point for receipt of quality assurance resources, including technical assistance by both the TA contractor and the MOH. The MQC Directorate should be the lead directorate in all areas of implementation, including the contact point for governorate programs. To assume its expected role in leadership, monitoring, and training, the capabilities of the MQC Directorate staff should be enhanced, and more staff should be added as the project expands.

4. The MQC Directorate's inspection role that is not related to quality assurance should be moved to a separate unit within the directorate.

5. Weekly meetings should be held among the directors of PPM, MQC, and URC to strengthen communications. These meetings could be the forum for the parties to discuss technical issues relating to quality assurance activities and to share information. The MQC Directorate should schedule these meetings. The line of communications by the TA

contractor should follow the usual MOH lines of authority.

6. The role of the PPM Directorate should be clarified as one of administration, as it is with other USAID projects, and not one of direct implementation.

7. The URC role should be clarified as one of providing technical assistance to the MQC Directorate to assist and enhance its ability to assume full responsibility for the QA program.

8. URC should encourage and assist the MQC Directorate in documenting quality assurance, cost reduction, and family planning studies in the Balqa Governorate and other governorates as the project expands.

9. An external assessment of all family health services/family planning training should be conducted. The project is expanding to other governorates, and the training is an important component of the expansion. More attention should be given to evaluating workshops and the impact of training, such as before and after comprehension tests.

10. URC should improve its data generation, retrieval, and presentation to ensure clarity, uniformity, and better organization.

11. Further technical assistance should be provided to the Perinatal/Neonatal Mortality Study to complete statistical handling of the data.

12. The Causes of Death, the Maternal Mortality, and the Morbidity and Health Situation Studies will not be completed by September 1996, the end of the URC extension. If it is desirable to have these studies finished as expected, it is recommended that additional technical assistance be provided.

13. The project should continue to emphasize the expansion of QA/FP to other governorates, with reduced support to the Balqa Governorate. During the expansion phase, greater emphasis should be given to MCH/FP centers rather than to hospitals.

14. Family planning should be given greater emphasis in the further expansion of QA/FP in other governorates.

15. The MOH should use Commodity Import Program funds to renovate the necessary MCH centers to expand the QA/FP component to other governorates. USAID should provide funds for technical assistance and to equip the centers.

16. In all improvement studies relating to MCH and family planning services, when possible and appropriate, emphasis should be given to reducing costs as part of improving quality.

17. Long-term technical assistance to the quality assurance program, with emphasis on the integration of family planning into MCH service activities, should be provided until the FHS project ends in 1998.

3. FAMILY MEDICINE SPECIALTY

3.1 Introduction

The Family Medicine Specialty training component of the FHS project started in August 1993 when the Cooperative Agreement (CA) with the Brown University School of Medicine and Memorial Hospital was signed. Furthermore, the implementers, i.e., Brown University, the University of Jordan, and the Jordan University of Science and Technology, signed their Memoranda of Understanding (MOU) in February 1994. This midterm evaluation coincides with the midpoint of this component of the project.

The earlier project's drafts specified the family health specialty as a merger between the MOH and academic institutions with the anticipation that graduates would be working in both private and public sectors. Such a specialty was foreseen as reinforcing primary health care, MCH, and the birth spacing orientation of Jordan's health system. And it was envisioned that such training programs would be based in the MOH with technical assistance and commodities provided through the project. The purpose of the CA with Brown University was to "develop and implement a Family Medicine Specialty (FMS) training program in Jordan," while the detailed activity description specified that it would "assist in the development and implementation of a high-quality, internationally acceptable, family health specialty training program in Jordan." The end of project (EOP) described in the FHS project's logical framework was the "Establishment of curricula and certification standards for a family health specialty."

Two objectives were identified during the evolution of the FHS project. These included the establishment of FMS training programs at UOJ and JUST and the upgrading of general practitioner training in the MOH.

Brown University, through its CA with USAID, was expected to assist UOJ and JUST and the MOH to achieve these objectives. Toward that, Brown was expected to undertake tasks including technical assistance, facilitation of training, and study/observation tours.

Technical assistance would include assistance in planning and management of the FMS training program at both universities and MOH, guidance on how to integrate principles of community medicine and public health into the FMS training program, provision of a faculty advisor who would dedicate 20 percent of his time in the first year, and as needed, to: 1) assure activities under the agreement are coordinated and monitored and training activities are properly managed and evaluated; 2) provide short-term technical assistance as needed to develop the family medicine specialty; and 3) arrange and manage all U.S. and third country study and observation tours for faculty and residents in family medicine.

Brown University was expected to assist in the 1) development of a detailed curriculum (time

frame, sequencing, modules, roles) for a FHS training program in the two schools of medicine, 2) facilitation of and assistance in building consensus on curriculum, 3) setting of standards for accreditation, 4) development of certification instruments through providing inputs and working closely with the Jordan Medical Council (JMC), 5) development of protocols for FMS training with emphasis on clinical integration of MCH and birth spacing activities, and 6) development of a comprehensive assessment and evaluation system for specialty rotations, educational activities, resident performance, preceptors, and faculty.

Brown University was expected to develop an in-service training for MOH physicians to improve the skills of MOH's PHC physicians in family medicine. This was to include development of curricula and protocols (in cooperation with UOJ and JUST), TOT, and the upgrading of three MOH centers to serve as training sites. Also, Brown was to provide advice on acquisition of materials for resource and training centers.

UOJ and JUST, under the MOU with Brown University, were expected to designate appropriate academic and professional bodies for the family medicine training program, designate necessary faculty, pay all related salary and costs associated with the training program, and develop health centers/clinics as training sites to be used as models for the MOH's PHC centers. These model centers were expected to be research facilities for the areas of community-based primary care, quality assurance, and cost effectiveness.

The MOH was expected to form a steering committee to oversee the project (technical guidance and oversight) and appoint a full-time MOH coordinator for the FHS training program. Project funds could support the salary and other expenses of the FHS training coordinator for up to four years, after which time these costs would have been assumed by the MOH.

3.2 Status/Accomplishments

3.2.1 Brown University School of Medicine and Memorial Hospital

The chairman of the Department of Family Medicine at Brown University and Memorial Hospital was designated as the resource person and faculty advisor (FA) for this Cooperative Agreement. The FA developed a detailed work plan for the life of the project (1994-1997), which was broken down by tasks for each institution involved, i.e., Brown, UOJ, JUST, and the MOH. The FA assisted in working out the details with both UOJ and JUST to institutionalize the FMS training program. This included setting objectives, staffing, establishing training and evaluation systems, curriculum, protocols, providing technical assistance, and the acquisition of resource material.

Detailed curricula were developed and they were approved by Academic Council of UOJ, apparently for the first and second year only. While the protocols continue to be developed and adapted, refining of an evaluation system and assessment of quality of training at the UOJ and

JUST were among the planned activities. The evaluation system is intended to cover specialty rotations, seminars and conferences, resident performance, faculty teaching, and ambulatory training.

Training of three residents in family practice at Brown University and in the U.S. was facilitated in anticipation that upon completion of this training, they would join the faculty in UOJ and JUST. A visiting professor from the American University of Beirut (AUB) participated in the introductory course for the residents. Initial contact was made with the American Board of Family Practice (ABFP) to arrange plans similar to those at AUB in Beirut.

3.2.2 University of Jordan

Family Medicine is a residency training specialty at UOJ that is overseen by a committee reporting to the Dean of Medicine. The dean represents UOJ in the MOU and seems to be supportive of the idea within limitations. The chairman of the Family Medicine Committee is a Professor of Community Medicine, and the committee includes members from the four major specialties (internal medicine, surgery, obstetrics and gynecology, and pediatrics). The family medicine specialty is administered as a division under the Department of Internal Medicine. The faculty includes one full-time and two part-time family medicine specialists. The faculty support is drawn from other clinical specialties. The coordinator of the family medicine training program is a full-time specialist. Faculty members from other departments do not seem to have internalized the philosophy of family medicine. They are involved with other roles and it appears as if the FMS effort is an extra burden. There was no consistency in the expected roles of the family medicine doctors after they complete their training. The dean and faculty (team of five members) visited Brown University in March 1994 and Bahrain and AUB in 1995.

UOJ sponsored two of its promising recent graduates to receive residency training in family medicine in the U.S. with the expectation that they would return as candidates for faculty appointments. This was arranged in order to fulfill the academic requirements stipulating a minimum of three full-time faculty members within the department to attain independent departmental status. The evaluation team gathered that these residents are not coming back to Jordan. The dean and faculty are searching intensively for faculty members but have no prospects for the future.

Detailed curricula for the two first years of training were developed, clinical rotations were scheduled in the clinical services of the Jordan University Hospital, and schedules for the four years training were drafted. The dean told the team that some administrative problems do exist between the UOJ and the Jordan Medical Council concerning the accreditation of the program.

The first group of four UOJ residents started their training in July 1, 1994, and they are in their second year of residency. Four more joined in July 1, 1995. The two residents interviewed were

critical of the training program for a number of reasons: the absence of role models; lack of tailored training toward independent decision-making; inconsistency in training curricula; and lack of clarity concerning their future careers. They felt that they needed more family practice oriented training, especially, in the ambulatory setting, and that further training might be needed in other health facilities, e.g., MOH and RMS facilities. They felt that the library resources were satisfactory.

Evaluation of the performance of the residents was done by the clinical preceptors on standard forms of residents' evaluation. Logbooks of residents' activities with monitoring by the coordinator were kept. Feedback mechanisms relating to the residents' training experiences were utilized by the coordinator.

Initially, plans were laid out for a family medicine training center within the premises of the Jordan University Hospital. More recently, an agreement was signed with MOH to utilize one of its comprehensive health centers as a training facility. The cost of upgrading it to meet training requirements will be covered by the project.

3.2.3 Jordan University of Science and Technology

Family medicine is a residency training specialty at JUST that is overseen by a committee reporting to the Dean of Medicine (who represents JUST in the MOU). The dean is the chairman of the Family Medicine Committee, and the committee includes members from the four major specialties (internal medicine, surgery, obstetrics and gynecology, and pediatrics). The coordinator of the specialty is the chairman of the Department of Community Medicine and Public Health. The coordinator shared with the team that JUST is intending to have FMS as a division under the Department of Community Medicine and Public Health. Currently, there are no faculty members who are specialized in family medicine; faculty support is drawn from other clinical specialties.

The quarterly reports showed concern that the coordinator does not have enough time to oversee the program. The team felt that the faculty seems to be involved with multiple roles and this poses an extra burden. There is no clear idea on the expected roles of the family doctors after their completion of the training. The dean and faculty visited Brown University in 1994 and Bahrain and AUB in 1995.

JUST sponsored two promising residents for training in family medicine in the U.S. to facilitate joining the faculty. As the team understands it, these residents are not coming back to Jordan.

Curricula for the two first years of training were developed, clinical rotations are in the clinical services of the Princess Basma Teaching Hospital (which is a MOH hospital but under agreement with JUST to utilize it as a teaching hospital).

The first group of four MOH-sponsored residents started their training in October 1, 1994, and now they are in their second year of residency. Only two residents joined the program in July 1, 1995; both were non-Jordanians on scholarships and one has left the program.

JUST has an agreement with MOH to utilize one of its comprehensive health centers for its service and training purposes. This center will be utilized for training family medicine residents.

3.2.4 Ministry of Health

In the early days of the Cooperative Agreement, the MOH appointed the steering committee and the family medicine coordinator. It appears to the team that they are no longer functioning.

Since the aim in the CA was to train MOH physicians, and the training was intended to be a collaboration between the MOH and the universities, it appears that the major thrust of the intended training program has shifted.

Except for very early reports on acquiring protocols to be adapted and training of trainers to strengthen MOH capacity in family medicine, it appears that nothing has happened since then at the MOH level.

Recently, it was agreed that funds allocated for the MOH component of the CA will be transferred to cover "seed money" toward covering the costs for remodeling the new family medicine center (MOH center five kilometers off the campus), which will serve as the training facility for ambulatory care.

3.3 Problems

3.3.1 Accreditation

The most urgent problem requiring attention is the status of accreditation of both training programs and certification requirements for the resident trainees. Unless this is done as soon as possible, the current and future residents run the risk of having the past training not recognized by the Jordan Medical Council, the ultimate authority on accreditation and certification. This concern was expressed by the current FM residents. In the long run, this problem could lead to a major setback for the family medicine specialty.

3.3.2 Recruitment of Faculty

The second most pressing need for the FMS programs relates to securing enough faculty in the two universities. The trial of sponsoring newly graduated doctors from the UOJ to be trained as FM residents in the U.S. has failed. Alternatives need to be found urgently, since there are very few qualified faculty members in Jordan.

3.3.3 Curriculum

The curriculum appears to have undergone many changes in the past two years. Some of these are

related to the accreditation and certification requirements, and others are related to attempts to accommodate the philosophy of family medicine in medical schools that have traditional specialty orientation.

3.3.4 Protocols

In spite of the fact that the CA for the FMS training program has been in effect for two years, no training protocols relating to the FMS residents or the MOH physicians were available for review. Furthermore, there was no indication that such protocols were being tested for appropriateness within the Jordanian context.

3.3.5 Training

The schedule of training of residents in the FMS program in both universities seems to follow the traditional rotations in clinical services. Assignments are either similar to the first year residents' of that service or even shorter, because the FMS residents are expected to spend a much shorter time in the rotation. The residents do not feel integrated into these rotations. Furthermore, the residents feel that they are involved mainly in service rather than tailored training.

There seems to be a need for other sites for FMS residents' training, since the university teaching hospitals are more of tertiary referral centers rather than general hospitals. Suggested alternatives include MOH and Royal Medical Services hospitals.

In the project documentation, it was planned that residents would be exposed to short-term U.S. and/or third country training program experiences in FM. No evidence of work in this area was seen.

3.3.6 Evaluation System

In spite of the plans for developing a comprehensive evaluation system for the different components of the activity, little work appears to have been done on these evaluation components.

3.3.7 Recruitment of Residents

The FMS training programs in both universities are new, thus the number of residents in each program are limited. These small numbers may be related to the limited slots for residents in the two teaching hospitals. The current residents (except for the four residents in JUST who are

sponsored by the MOH) are not inclined to practice within the MOH centers.

3.3.8 Role of MOH

MOH is the main provider of primary health care in Jordan. The need to re-train newly appointed new graduates from different schools of medicine is vital for the improvement of the quality of family health services and for the integration of MCH/FP services. The planned training of MOH physicians however, has not been implemented. Neither of the current two programs in the universities will address the needs of the MOH adequately.

3.3.9 Coordination of UOJ and JUST

UOJ and JUST are both initiating two FMS programs that appear very similar. The UOJ program was fortunate to have one full-time faculty and two part-time family practitioners. The resources available to both universities might complement each other. Currently, coordination between the two institutions is limited to ordering of resources and introductory courses.

3.3.10 Sustainability

Unless the two urgent problems of accreditation and faculty enhancement are addressed, the viability of the program is in jeopardy. Furthermore, the long-term sustainability of the specialty is under scrutiny. While some health system interest groups are in favor of the idea, it seems more are in opposition.

Perceptions of the effect of the new family practice specialty on the practice market shares of the specialists and potentially on the untrained general practitioners seem to be affecting the attitudes toward this specialty.

3.4 Indicators

The indicator listed in the logical framework was the development of curriculum and certification standards. The expected outputs were formal acceptance of physicians into the specialty, graduation of specialists in family health, up to six residents trained in the U.S., and up to six residents trained in third countries. It was assumed that the certification standards would have been adopted and accepted by the medical community.

Useful additional indicators for monitoring these activities would be the presence of a new EOP, "An accredited family medicine specialty training program established at two Jordanian

universities." Further indicators would be helpful if they address the problems and the recommendations.

3.5 Institutional Performance

Although MOH fulfilled what was mandated under the Agreement in terms of the Steering Committee and the full-time Coordinator, the re-direction of the activities to the universities appears to have affected the component of the FMS training allocated to MOH to meet its needs to have well-trained PHC physicians.

It appears that both universities have academic requirements that cause curricula and training schedules for the FMS training program not to be in compliance with the JMC requirements for accreditation and certification. Currently, it seems that clinical instruction is not addressing the specific needs of the FMS trainees, and the demands of the service component seriously impinge on the educational and training component.

Originally, the Cooperative Agreement suggested that select faculty members from different clinical specialties (five from each university) would be trained and exposed to the process of training FM residents in the U.S., including the participation in the teaching activities.

Both universities were late in developing health centers/clinics as training/research sites. Although JUST has designated a well-equipped comprehensive health center, training activities are not yet implemented.

3.6 Effectiveness of Technical Assistance

The CA mandated Brown University to supply technical assistance to facilitate harmonious working relations among the different players in the health system and to provide guidance in policy development toward accreditation and certification of the new specialties at both universities. It seems that this part was not given enough attention and should have been followed up more closely.

More short-term TA could have been utilized to make up for the shortcomings of curriculum development, setting protocols, and implementing evaluation processes.

3.7 Lessons Learned

When assumptions are made, they need to be revisited every now and then. The reality of potential changes in the power structure within the health system makes it necessary to do that often. (It was assumed that the certification standards would have been adopted and accepted by the medical community.)

Background papers and technical analyses of the Project Paper described in detail the expected constraints to this specialty (e.g., faculty limitation, sensitivity of different subsectors [Project Paper, pages 68-74]), and the current sensitivities were well described as early as 1990. Brown University was to conduct its activities in full compliance with the laws and regulations of the Hashemite Kingdom of Jordan, where the ultimate authority of accreditation and certification is mandated by law to the Jordan Medical Council.

Creation of new programs from top down usually encounter a lot of problems. In this example, the "felt need" is at MOH and the private sector, while the implementation is in academia. To address needs of both public and private sectors with regards to family medicine specialists, different marketing strategies will be needed.

3.8 Conclusions

Generally, the first objectives relating to the establishment of FMS programs at UOJ and JUST received the main attention, while the objective to upgrade training of general practitioners in the MOH was hardly addressed during the first two years. After the reorientation of the FMS, it was

agreed that the MOH component of the CA would be changed to the upgrading of one MOH center to serve as a training site for FMS residents of UOJ. Therefore, the steering committee and the coordinator of FMS in the MOH were expected to be no longer active. The two universities (UOJ, JUST) differ in their accomplishments toward the endpoints of the CA. Different inputs and processes toward the development of the new specialty were utilized. FMS training programs in both universities are not yet accredited by the Jordan Medical Council. As of midterm, the outputs are not serving the ultimate objective of the project.

3.9 Recommendations

18. Brown University, UOJ, and JUST should act immediately to bring UOJ and JUST into compliance with the Jordan Medical Council certification requirements for family medicine residents. If the issue of accreditation is not solved by July 1, 1996, USAID should give serious consideration to moving the entire program to the MOH or other appropriate solutions.

19. Brown University, UOJ, and JUST should address the issue of inadequate exposure of family medicine residents to the technical and philosophical aspects of clinical management for independent decision making. This is important for residents' future practice. Formation of a family medicine department in each institution would contribute to a resolution of this issue.

20. Brown University, UOJ, and JUST should consider a more appropriate way to secure faculty for the family medicine specialty as the current method of sending residents to the United States is not working.

21. The MOH should be more actively involved in recruitment and should ultimately support eminently qualified residents for the family medicine program. If the MOH recruitment fails, the objective of training family medicine physicians to work in primary health care centers may not be reached as the university recruited residents may go into private practice.

22. Brown University, UOJ, and JUST should ensure that adequate training in family planning services is included in the family medicine program.

23. UOJ and JUST should confer with Brown University to assess the program evaluation instruments and to ensure that they conform to family medicine educational requirements.

4. JORDAN ASSOCIATION FOR FAMILY PLANNING AND PROTECTION

4.1 Introduction

The private sector and NGOs are important family planning service providers in Jordan. Results of the 1990 Population and Family Health Survey showed that approximately 75 percent of all women who use modern contraceptives obtain them from a private sector source with 30 percent of the total users obtaining services from the Jordan Association for Family Planning and Protection (JAFPP).

Under the FHS project JAFPP receives support through a Cooperative Agreement with Pathfinder International. The initial CA provided support to JAFPP for three years (June 1992-July 1995). A modification in June 1995 extended the CA until June 1997.

The assistance to JAFPP was framed within JAFPP's commitment to the expansion of family planning awareness and service in Jordan, through continuing collaboration, participation, and leadership in quality of care. Specifically, Pathfinder is to assist JAFPP in clinic service expansion and quality of care.

4.2 Clinic Services Expansion

4.2.1 Status/Accomplishments

Under the Cooperative Agreement, Pathfinder is to support the establishment of up to five clinics. Support includes equipment, furniture, and renovations as well as annual operating costs associated with staff, rents, supplies, maintenance, etc.

In the first three and a half years of the CA, Pathfinder and JAFPP established the authorized five new clinics. The five clinics opened were Mafraq and Ruseifah, April 1993; Irbid, October 1993; Quesmah, August 1994; and Wadi Alser, January 1996.

The team visited the JAFPP/Pathfinder Quesmah clinic and the JAFPP clinic in Ashrafiah. Both clinics appeared to be very clean and well maintained, allowed an easy flow of clients, and had female doctors.

According to the staff, the Quesmah clinic's location is excellent because it is in a lower income area. The Quesmah staff appeared very committed to quality of care and client satisfaction. The three staff members interviewed have received training in counseling and the doctor has received training in reproductive health, infection control, and the recently introduced injectables.

The first four JAFPP/Pathfinder clinics appear to be operating as expected in good facilities with adequate equipment and well trained motivated staff. It appears that clients are receiving high-quality care. JAFPP's 1993-1995 data for these four clinics show an increase in the number of clients for both family planning services and other services such as pregnancy tests and gynecological exams. The intrauterine device (IUD) is the most popular method. The two clinics (Irbid and Mafraq) that appear to have a high IUD discontinuation rate are discussed below.

4.3 Quality of Care

The second area of support by Pathfinder is quality of care. The activities supported under this component are a clinic management information system (CMIS), training, the maintenance of clinic-based quality assurance systems, salaries for some staff including a clinic relief team, and assistance in developing a self-sufficiency plan.

4.3.1 Clinic Management Information System

Status/Accomplishments. The purpose of the CMIS is to assist JAFPP in developing its ability to analyze, interpret, and make use of the data generated through the CMIS for decision making. Assistance will include training in the use and maintenance of the computerized systems.

The software for the CMIS was developed in Ireland through the International Planned Parenthood Federation (IPPF). The system is being tested in Jordan. The basic clinic module of the CMIS was demonstrated and installed in May 1995. It is anticipated that other modules will be added to the system at a later date. Training has been provided to both headquarters and clinic staff. Apparently, all staff are having problems in learning the system and once the foreign expert leaves there is no knowledgeable backup resource person to resolve problems.

The basic clinic module is being tested in four clinics, including Ashrafiah where the team was given a demonstration. The basic clinic module includes minimum information and is only being used for new clients. At a later date additional information will be gathered. Also, the clinics are still using the old handwritten forms as a backup system. In the Ashrafiah clinic, the receptionist gathers the information from clients by asking several sensitive questions that many women may be reluctant to answer in a public area such as a clinic waiting room (e.g., religion and income level).

Problems. Based on observations of the system in Ashrafiah and conversations with JAFPP staff, it appears that the current CMIS is too complicated and needs additional translation into Arabic. Because the system was developed by IPPF, the technical support for the system is external and not easily accessible to JAFPP. To ensure that the CMIS can gather the information needed and

use the data for decision making, the system must be user-friendly. It was also unclear if the information gathered from implementing the full client record will be produced in a form that will be useful to JAFPP management.

It was not clear who was responsible for CMIS within JAFPP. While the computer operator is conducting training to make the CMIS ultimately useful to JAFPP, the CMIS must have strong input and support from JAFPP management.

4.3.2 Quality Improvement

Status/Accomplishments. JAFPP and Pathfinder recognize the importance of quality of care and numerous activities have taken place to improve the quality of care at JAFPP clinics, including the following:

- Under the USAID/GOJ project, Marketing of Birth Spacing, a JAFPP client satisfaction survey was conducted. The results of the survey should be available by March 1996.

- A quality assurance coordinator was hired in late 1995. She is currently developing infection control guidelines and a monitoring checklist.

- In 1995 a workshop was conducted to identify a manageable number of quality of care (QOC) indicators. In early 1996 another QOC workshop will be conducted to refine the indicators.

- Training of staff has occurred in areas such as early detection of cervical cancer, clinical management, cervical erosion, infection prevention, contraceptive technology, and counseling.

- By analyzing IUD discontinuation forms, JAFPP and Pathfinder discovered that there were too many IUD removals at two clinics. The staff of the two clinics will receive additional counseling training.

Problems. Pathfinder should assist JAFPP to develop a plan based on data gathered by JAFPP for improving continuation rates through better counseling, client follow-up, or other effective means. The plan should identify changes, if any, needed in the service statistics system to establish an early warning system of discontinuation problems. As the CMIS is being developed, these concerns need to be included in the system, otherwise consideration should be given to including data that will allow such analysis.

To measure the effect of its focus on quality improvement, JAFPP should continue to conduct before and after clinical improvement studies. These studies could be used as training tools and as examples for other clinics; the studies can be analyzed by Pathfinder and JAFPP for broader applications and be used for project evaluation.

4.3.3 Financial Planning

Status/Accomplishments. Currently JAFPP receives funding from numerous sources; however, cost recovery is a concern as the funding is limited and can be withdrawn. JAFPP has implemented several strategies to address the cost-recovery issue. The fee schedule is reviewed every year and in 1995 JAFPP increased the fee for pap smears from 2JD to 3JD (Jordanian dinar). In addition, JAFPP is funding an information, education, and communication (IEC) campaign to expand its client base.

At the end of 1995, the first four JAFPP/Pathfinder clinics were recovering an average of approximately 52 percent of costs. For two reasons it is unclear at this stage what the percentage of cost recovery will be when the CA ends in 1997. First, at the design phase of the Pathfinder Cooperative Agreement, JAFPP, USAID, and Pathfinder agreed to open additional clinics to reduce client overload to ensure quality of care, thus trading off higher cost recovery at some JAFPP clinics. Second, women now have more options for obtaining family planning services. The number of private sector doctors trained in family planning has increased and the Ministry of Health, through support from USAID and the United Nations, has increased the availability of family planning services.

Problem. Pathfinder should give priority to assisting JAFPP to develop a plan to increase cost recovery and self sufficiency. Some of the issues that should be addressed are whether JAFPP can absorb the costs of the salaries of the relief team and other personnel currently funded by Pathfinder, and what impact, if any, will the FHS/MOH and UN/MOH expansion of family planning services have on JAFPP and its self-sufficiency goal.

4.4 Effectiveness of Technical Assistance and Training

The technical assistance that Pathfinder has provided to JAFPP has been appropriate and consistent. The need for providing focused assistance to JAFPP is discussed above.

The training provided has been relevant to JAFPP. There appears to be a need for more concentrated CMIS training; however, that may be an IPPF responsibility.

4.5 Conclusions

The JAFPP clinics are very impressive and their staff is motivated and loyal. Now that the five clinics are open and operating, JAFPP and Pathfinder should concentrate on implementing the CMIS, continuing and improving quality of care, and addressing the cost-recovery issue.

4.6 Recommendations

24. Before expanding the current clinic management information system to all JAFPP clinics, Pathfinder and JAFPP should obtain technical assistance to review and assess the current CMIS system to determine if it can fulfill the needs and expectations of JAFPP and to determine if the current system is too complicated for the requirements of JAFPP. The option of obtaining local service support should be reviewed at the same time.

25. Pathfinder should continue to assist JAFPP to conduct before and after clinical improvement studies to measure impact of quality of care improvements.

5. NATIONAL POPULATION COMMISSION INFORMATION, EDUCATION, AND COMMUNICATION PROJECT

5.1 Introduction

The National Population Commission (NPC) and USAID signed a grant for an IEC project on May 21, 1995. The stated goal of the NPC IEC project is to support the National Program of Birth Spacing component of the National Population Strategy by promoting increased support for and use of birth spacing services in Jordan. The project has two clusters of objectives:

- Institution-building: 1) to increase NPC staff capabilities in the design, production, pretesting, and dissemination of IEC materials and activities, 2) to enhance the role of NPC in the coordination of population IEC activities in Jordan;

- Information, education, and communication: 3) to increase support for the birth spacing programs among Jordanian policy-makers, leaders, and individuals, 4) to increase the percentage of Jordanian men who report having a positive attitude toward birth spacing, 5) to increase the number of Jordanian couples who have visited a health center for birth spacing information or services.

These five objectives are to be achieved through the provision of IEC training and relevant resource materials for NPC staff, and through NPC's implementation of a mass media campaign complemented by advocacy activities. The media campaign and advocacy activities are to be carried out in collaboration with private production and research agencies in Jordan, as well as with relevant governmental and nongovernmental agencies. Technical assistance is to be provided by the Johns Hopkins University Population Communication Services (JHU/PCS)/Population Information Project.

5.2 Status/Accomplishments

The project has just started and appears to be getting off to a good start. An advisory committee had been formed and it consists of a NPC representative, a MOH representative, health professionals including physicians and nurses, and various media persons.

An IEC person has just been hired, and she will receive training in Indonesia. IEC materials are being collected, and a new publication has just been produced. The JHU/PCS consultant has been quite helpful in completing this task. Audiovisual materials are being collected. A vehicle to be used for disseminating messages all over the country has just recently been procured. Focus group discussions have been initiated, and a study of the results of these discussions will be available next month.

Additional activities are under discussion with USAID with the advice of the JHU/PCS consultant. These include a knowledge, attitude, and practice (KAP) survey, a media survey, outreach strategy design, and the development of media materials including booklets, pamphlets, and TV spots.

A recent add-on to the JHU/PCS project by USAID will support a resident advisor to train staff and assist in the development of media materials and the design and implementation of the KAP study.

5.3 Problems

The project is just starting, and no problems have been encountered; it is making good progress.

5.4 Conclusions

This component appears to have a high potential for success, and thereby will serve as a very logical and desirable addition to the other components of the project. It will be important to closely document achievements as activities gain momentum.

5.5 Recommendations

26. NPC should be encouraged to develop a system to document its accomplishments and its impact.

27. The plan to hire a full-time IEC advisor for the NPC component is an excellent idea and should be pursued.

6. FINANCING

6.1 Introduction

The Family Health Services Project is an eight-year (September 1990-September 1998), US$7 million project. The entire US$7 million has been obligated. Due to the delays in starting the URC and Brown University technical assistance, and the delay in starting the NPC component, the current pipeline for the project is large (US$4.6 million). However, based on current rates of implementation, this does not seem to be a long-term problem. Also, there are sufficient funds in the project for the Mission to procure the two years of additional technical assistance that are needed for the FHS/quality assurance/family planning component after the current CA with URC ends.

No financial issues exist at this stage of the project. Funds appear adequate for the proposed activities and no problems with disbursements to contractors were reported.

6.2 FHS Project Pipeline Analysis

Table 1

Pipeline Analysis as of January 31, 1996 (in thousands of US$)

Element	Obligated	Committed	Accrued Expenditures	Pipeline
TA	$2,563	$1,247	$1,185	$1,378
Training	$1,460	$ 792	$ 627	$ 833
Commodities	$1,277	$ 649	$ 45	$1,232
Other Costs	$1,400	$1,395	$ 540	$ 860
Contingency	$ 100	--	--	$ 100
Evaluation	$ 200	$ 77	--	$ 200
TOTAL	$7,000	$4,160	$2,397	$4,603

Note: The Accrued Expenditures column includes expenditures reported by USAID/Jordan. Some under-reporting exists in this item due to omission of expenditures by USAID/Washington contracts that have not yet been communicated to USAID/Jordan.

7. PROGRAM MANAGEMENT

7.1 Introduction

The FHS project consists of Cooperative Agreements, USAID procurement, contracts, and grants. Overall administration of the FHS project is by the PPM Directorate in the MOH. The FHS/QA/FA component is implemented by the MQC Directorate in the MOH. In addition, the NPC, JAFPP, UOJ, and JUST are responsible for implementing their specific components of the project.

7.2 FHS Project Management Arrangements

7.2.1 The Institutional Contracts

1. The University Research Corporation of the Center for Human Services (URC/CHS) assists the MOH (two directorates within the Ministry and governorate level hospital and health directorate staff) to implement the FHS/quality assurance/family planning component of the project. Due to the delay by USAID/Washington in processing the add-on, and because the URC/CHS contract with USAID at that time ended in March 1996 (it was recently extended to September 1996), the Scope of Work that was originally written for three years has been compressed into just over two years.

   Project implementation started quickly after the signing of the contract with the arrival of the long-term advisor, the setting up of the project office, and hiring of staff. Quality assurance activities started in Salt Hospital and were later expanded to the MCH/family planning model clinic. The MQC Directorate staff were trained locally and observed quality assurance programs in the U.S. People at the governorate level were trained. Recently the quality assurance and family planning activities have been expanded to two other governorates.

   The implementation of the project in the last year has been somewhat delayed due to the turn-over of resident advisors. The first resident advisor left after one year (February 1994-January 1995) and an interim advisor was in place until the current resident advisor arrived in August 1995. Due to the vague lines of technical implementation responsibilities within the MOH, some communication problems occurred among the various parties including the URC resident advisor. These appear to have been solved and all parties are now working on cooperating and communicating better.

   As the FHS/quality assurance/family planning component of the project expands to the other 11 governorates, URC and USAID should consider adding additional technical staff

to the URC and authorizing short-term technical assistance as required. Recommendation No. 17 states that long-term technical assistance to the FHS/quality program should continue after the current contract expires. This could be done through a buy-in or a sole source to URC if desired.

The team recommends that USAID/Jordan should include funds for equipping the MCH/FP model centers for the expansion phase of this component in the new contract to ensure timely delivery of the equipment.

2. Brown University has a CA with USAID/Jordan to provide technical assistance to UOJ and JUST to implement the family medicine specialty training program. As discussed earlier, that component appears to have some major issues that could impact on the viability of the training program. If these issues are resolved, Brown University should try to maintain closer contact with the individual programs to ensure that they are being implemented as expected.

3. Pathfinder provides technical assistance to the JAFPP. Its Cooperative Agreement with USAID/Jordan expires in June 1997. Since July 1995, Pathfinder has had a Jordanian representative who is responsible for the day-to-day technical assistance to JAFPP. Now that the five new clinics have been established, Pathfinder and JAFPP should concentrate on developing and institutionalizing the quality of care systems, including the CMIS. Also, if needed, Pathfinder should provide external technical assistance to help JAFPP in their cost-recovery and self-sufficiency plan.

7.2.2 Population and Family Health Office

The Population and Family Health Office in USAID/Jordan has managed the FHS project with an emphasis on the involvement of the resident advisors, Cooperating Agencies, the MOH, and other Jordanian institutions that implement the project. In the future, the USAID Population and Family Health Office (PFH) should consider encouraging the use of short-term local and external technical assistance to the various components of the project. Add-on funds, Cooperative Agreements, and grants have been expended in a timely fashion.

The FHS/MCH/FP model clinic, the URC, and JAFPP complained of contraceptive shortages. The PFH Office has responded by obtaining technical assistance from USAID/Washington to assess the MOH logistics system and to make recommendations. In addition, they are working with the United Nations Population Fund and USAID/Washington on short-term solutions to the shortages. The PFH Office is handling this problem promptly and efficiently; therefore, the evaluation team made no recommendations.

8. PROJECT PURPOSE, END-OF-PROJECT STATUS, AND STRATEGIC OBJECTIVE

8.1 End-of-Project Status and Project Purpose

The original purpose of the Family Health Services Project was to improve the quality and increase the cost efficiency of primary health care services provided in the public sector and to utilize private-sector health care providers more effectively to achieve national family health care goals. At that time the project contained four components: 1) Health Planning Analyses; 2) Health Financing Interventions; 3) Family Health Services; and 4) Support to the General Secretariat of the National Population Commission.

Although the FHS project was designed and developed in 1989 and authorized on August 18, 1990, the signing of the Project Agreement with the Government of Jordan was delayed until September 1991 due to the Gulf War. Because of this delay and changes in the Government of Jordan's health care policies, the project was modified in August 1991.

The modification changed the project design so that the project would be implemented in two phases. Phase I was to be essentially a preparatory phase, devoted to completing necessary health financing studies, testing and developing intervention strategies, and identifying and selecting the most appropriate financing strategies and service delivery approaches through government and private health centers and clinics. Phase II was to be the implementation phase. Also, at the time of the modification, USAID/Jordan included in the original Project Agreement a condition that Phase I activities had to be completed before additional funds would be disbursed.

In addition, the modification divided the project into two components: 1) Health Care Planning and Financing and 2) Family Health Services. The Health Care Planning and Financing component was to assist the MOH to improve health sector planning and to develop appropriate health care financing strategies to reduce the costs to the government for health care programs.

The Family Health Services component would improve the quality of family health services provided through government health centers and clinics, support a family medicine specialty training program, support the NGO sector, and support the National Population Commission.

In 1993, the project was once again redirected when the World Bank and the GOJ signed a US$20 million health sector loan that included substantial funds for improving the hospital sector and for studies relating to hospital management, health care financing, and health sector policy. Because of the World Bank loan which duplicated the health care financing efforts in the project and at the request of the MOH, the Mission dropped Phase I of the project which included the health care planning and financing component and the related studies (a study of the current hospitals situation, a comprehensive health sector strategy, and a plan to introduce appropriate

health care financing). At the same time USAID/Jordan removed the condition in the Project Agreement that Phase I activities has to be completed before additional funds would be disbursed.

In late 1992 at the time of the World Bank loan negotiations, USAID/Jordan adopted "fertility reduction" as one of its three strategic objectives for Jordan. To achieve its fertility reduction objective the project was expanded by integrating birth spacing and family planning into MCH services while improving the quality of family health services of government health centers and clinics. The funds reserved in the FHS Project Agreement for Phase I activities were moved to the Family Health Services component.

As discussed in detail above, the family medicine specialty training program as designed in the Project Paper was envisioned to be in the Ministry of Health. In early 1993, a decision was made to start this program at UOJ and JUST instead of the MOH. In addition, the NPC component was changed because it was felt the strength of the NPC was not in demographics; however, there was a need for a national IEC strategy and the NPC was the logical choice.

In late 1995, as part of a USAID "re-engineering process," USAID/Jordan refined its Strategic Objective No. 3 to be "Increased Practice of Family Planning with an Emphasis on Modern Methods."

In discussions with the MOH and USAID/Jordan, it is clear that the end of project status has been revised for the reasons discussed above. The original and the revised EOPS are found in the following chart. The team suggests that the MOH and USAID exchange a Project Implementation Letter confirming the mutually agreed upon EOPS.

The project seems to be on schedule for achieving most of the revised EOPS if the recommendations included in this report are implemented.

The project purpose of improving the quality and increasing the cost efficiency of broad-based primary health care services in the public sector, and utilizing the private-sector health care providers more effectively to achieve national goals, remains essentially the same. However, the project will now focus on cost savings realized by improving quality.

Table 2

Original End of Project Status (EOPS)

ORIGINAL EOPS	STATUS
1. MOH is incorporating current PHC service delivery costs and revenue into annual planning process.	Dropped by USAID in March 1993 through Project Agreement No. 1 because the World Bank Health Sector loan assisted the GOJ in health care financing and the health sector strategy. Also USAID/Jordan reoriented the project to the Mission's new strategic objective of "fertility reduction."
2. Assessment of client revenues and recurrent costs completed. MOH is testing alternative cost-recovery programs.	See No. 1. above.
3. Increased number of private physicians are providing primary health care services.	Dropped by USAID from this project. Some training of private physicians in family planning has occurred under the USAID Marketing of Birth Spacing Project.
4. MOH is developing health strategy with new policy directions.	See No. l. above.
5. Up to 250 primary health care centers are providing improved services in health care delivery and birth spacing.	Dropped by USAID from this project. The UN is assisting the MOH to integrate family planning into public sector clinics.
6. Curriculum and certification standards of family health specialty developed.	See revised EOPS, No.7 in table 3.
7. Up to 700 community health workers providing birth spacing information and education.	Focus changed to training of clinic personnel as a UN/MOH project focuses on expanding family planning services. See revised EOPS No. 2 (table 3).
8. JAFPP and other NGOs able to manage and expand clinical program of birth spacing services delivery.	See revised EOPS No. 6 (table 3).
9. NPC is regularly generating reports concerning impact of demographic variables.	Refocused. See revised EOPS No. 8 (table 3).

Table 3

Revised End of Project Status (EOPS)

REVISED EOPS	STATUS
1. Improved standards and protocols for FHS/MCH/FP.	A list of over 80 standards, protocols, guidelines, and public education pamphlets are completed and in various stages of approval and review.

2. Up to 500 clinic personnel trained in improved quality assurance management and integrated FHS/MCH/FP service delivery techniques.	510 individuals have attended at least one workshop, and 43 attended at least 3 (almost all these trainees were from Balqa). Ratio QA awareness to QA FP is 3:1.
3. An effective referral system between health centers and hospitals has been established and functioning with an emphasis on CPP hospitals.	Referral system designed in Balqa. Protocols being reviewed. Coordination with CPP systems awaiting designation of CPP hospitals.
4. A national FHS quality assurance system has been established and functioning.	The MQC Directorate established. The MQC Directorate needs to be strengthened in order to assume its expected role.
5. Reduction in costs at model sites resulting from quality assurance.	A few cost-related quality improvement studies just beginning.
6. An increased number of NGO clinics providing birth spacing and family planning services.	Five new JAFPP clinics established and functioning.
7. An accredited Family Medicine Specialty training program has been established at two Jordanian universities.	Training programs have been established in both universities. Potential accreditation problem.
8. The NPC will develop and implement a national IEC strategy.	Activity started in late 1995.
9. Twelve new model MCH/FP model centers will be operating by the end of the project.	One model clinic is operating. The remaining 11 will be operating by end of the project.

8.2 Strategic Objective No. 3

The current FHS project will assist USAID/Jordan in achieving its Strategic Objective No. 3. (SO3): "Increased Practice of Family Planning with an Emphasis on Modern Methods."

The FHS project will contribute directly to two of the Results Packages (RP) and the performance indicators.

RP1 - Improved Knowledge of Contraceptives

Indicators:

1. 60 percent of married couples of reproductive age (MCRAs) correctly comprehend a given message.

2. 60 percent of MCRAs exposed to a specific message reported liking it.
3. 2,000 trained service information providers are able to communicate correct information to the MCRAs in the clinics and pharmacies.

The NPC component of the project, developing an IEC strategy and IEC materials, will assist in reaching the first two indicators above. The service providers at the JAFPP and MOH model FHS/MCH/FP centers will receive training to improve their counseling skills and thus help to reach the third indicator.

RP2 - Increased Availability of Family Planing Services

Indicators:

1. The number of NGO clinics which provide a "full range" of quality FP services increases from 14 in 1995 to 17 in 1998.

2. The number of public sector sites which provide a "a full range" of quality FP services increases from 63 in 1995 to 133 by 1998.

3. The percentage of women who receive postpartum care in the 12 postpartum centers increases from 6 percent in 1990 to 60 percent in 1998.

4. By 1998, 75 percent of all service sites which form the contraceptive distribution system report no stock-outs for the one year period.

The opening of the new JAFPP clinic in 1996 will make it easier to reach Indicator No. 1 above.

The expansion of the FHS/MCH/FP model centers to an additional 11 governorates by 1998 will assist in reaching Indicator No. 2.

If the family medicine specialty training program is successful in developing a cadre of family medicine doctors that are advocates for family planning and birth spacing, they could make a significant contribution to SO3. They would be working at the community level and therefore would have access to women and families.

A less quantifiable element of the FHS project that will make an important contribution to the eventual attainment of SO3 is the quality assurance activities to be initiated at the MOH/MCH/FP model centers and the quality of care activities currently being implemented at the JAFPP clinics. There is little doubt that raising accessibility and acceptability of services within the context of a systematic program of continuous quality improvement will have three desired effects: 1) increased use of the services; 2) reduction in inappropriate services and complications with resultant savings; and 3) improved contraceptive continuation rates.

The team made the following recommendations (discussed previously as recommendation numbers 13 and 14, page 19) to assist the FHS project to contribute to SO3.

8.3 Recommendations

- The project should continue to emphasize the expansion of QA/FP to other governorates with reduced support to the Balqa Governorate. During the expansion phase, greater emphasis should be given to MCH/FP centers rather than to hospitals.

- Family planning should be given greater emphasis in the further expansion of QA/FP in other governorates.

APPENDICES

EVALUATION SCOPE OF WORK
FAMILY HEALTH SERVICES (FHS) PROJECT

I. Introduction

USAID/Jordan has a seven-year (September 1991 - September 1998), $7 million project with the Jordanian Ministry of Health for the purpose of improving quality and cost effectiveness of maternal and child health and family planning services, including the development of a Family Medicine Specialty Program to train a new cadre of primary care physicians in Jordan. The project is being implemented with the assistance of three cooperating agencies: Pathfinder International, Brown University/Memorial Hospital of Rhode Island Department of Family Medicine, and the University Research Corporation (URC) Center for Human Services. Recently, a grant was given to the National Population Commission (NPC) along with Technical Assistance from Johns Hopkins University. The evaluation will examine the FHS Project's progress towards meeting its objectives and determine the extent to which the project is consistent with the Mission's "Increased Practice of Modern Family Planning Methods" strategy.

II. Project Information

Project Name and Number	Family Health Services Project 278-0287
Cooperative Agreements	URC/Human Services, DPE-5992-A-00-0500-00
	Pathfinder, DPE 278-0287-A-SS-2008-00
	Brown University, 278-0287-A-SS-3005-00
Grant	National Population Commission Grant 278-0287-G-00-5549-00
Life of Project Amount	$7 million (total is obligated)

III. Purpose of the Evaluation

A. This is a mid-term evaluation. It will be used to determine the status of the project in relation to the project purpose and its conformance with the Mission's "Increased Practice of Modern Family Planning Methods" Strategic Objective. It will identify accomplishments and problems and make specific recommendations for action to the Mission.

B. Major issues. The FHS project was designed before the Mission adopted "Increased Practice of Modern Family Planning Methods" as a Strategic Objective. The evaluation should help determine the extent to which the Project, as currently structured and implemented, is or is not contributing to the achievement of this objective.

IV. Background

Overall economic conditions: Jordan has a population of over 3.8 million, and an annual growth rate of 3.4 percent, one of the highest in the world. At this rate, the population will double in less than 20 years. While the population has nearly trebled in the past three decades (1961-1991), per capita income has declined from $2,310 in 1966 to about $1,200 in 1993. The Gulf War had a serious impact on the economy with trade losses with Iraq estimated at $2 billion alone. An estimated 250,000 Jordanians and Palestinians returned to the Kingdom due to the War. Unemployment is estimated at 18 percent. Current Government of Jordan (GOJ) analyses indicate that the economy is responding to macro-economic reforms, donor assistance, and debt rescheduling and forgiveness; 1994 GDP growth is estimated at 5.5 percent. The recent peace accord with Israel is expected to bring additional economic gains from improved trade, tourism, water resources management, and foreign investment.

Mission Strategy: In 1995, reengineering affected USAID missions worldwide. In USAID/Jordan, reengineering resulted in a revised mission goal of "Broad Based Sustainable Economic Growth and Stabilizing Global Population" supported by the following strategic objectives:

1. Increased foreign exchange earnings from cultural and nature visitors (CNVs) to Jordan.

2. Improved quality and increased quantity of water available for use on a sustainable basis; and

3. Increased Practice of Modern Family Planning Methods.

Currently, the Mission has three projects in support of the third Strategic Objective: 1) The Marketing of Birth Spacing Project, designed to develop a viable marketing system for contraceptive products; 2) the Comprehensive Post Partum Project, designed to increase post partum contraceptive prevalence by 50 percent; and 3) the Family Health Services Project, designed to "improve the quality and cost-effectiveness of family health services in the public sector and to increase effective utilization of NGOs, e.g. Jordan Association for Family Planning and Protection (JAFPP) in order to help achieve the national health care goals." (The FHS Project was designed before USAID/Jordan adopted the early on Strategic Objective of Fertility Reduction, or the most recent Strategic Objective "Increased Practice of Modern Family Planning

Methods). The FHS project is being implemented by the Ministry of Health, JAFPP, University of Jordan, Jordan University for Science and Technology (JUST), and NPC. Presently, health care costs represent a little over 10 per cent of the GDP and over 9 per cent of the national development budget. Forty percent of the health care expenditures are private.

Project Description: The FHS project was originally designed with two main components: (1) Health Care Planning and Financing and (2) Family Health Services. The Planning and Financing component is designed to assist the MOH improve health sector planning and develop appropriate health care financing strategies to reduce the cost to the Government. This component of the project calls for studies of a representative sample of public and private sector providers to determine the relative costs of various services, to identify management problems and to recommend appropriate financing strategies. The Family Health Services component was designed to improve the quality of services at government health centers and clinics. This is being accomplished through a better definition of roles and functions of the various facilities, development of uniform standards for delivery and the upgrading of skills of health center and clinic staff.

Although the FHS Project was designed and developed in 1989 and formally authorized for LOP funding of $7,000,000 on August 28, 1990, the signing of the Project Agreement with the Government of Jordan was delayed until September 1991 due to the Gulf War. Because of this delay and related changes in original project conditions and assumptions, a Project Paper Supplement was approved by the Mission Director on August 20, 1991. This Supplement deemphasized the Health Care Financing Component and placed greater emphasis on improving the quality of family health services and on NGO service delivery expansion. The Project Agreement was amended (Amendment No. 1) on March 3, 1993 to increase obligations from $3.5 million to $6 million, and further on September 21, 1994 (Amendment No. 2) to increase obligations to the full LOP level of $7 million. Much more emphasis, and funding, was provided to the Family Health Services and NGO components in this amendment to incorporate family planning information and services while improving the quality of FHS, following the adoption of Fertility Reduction as a strategic objective by the Mission at that time.

The project contains the following components:

A. Family Health Services Studies Component

1. Epidemiological Study
2. FHS Costs Study
3. Maternal Mortality Study
4. Perinatal and Neonatal Study
5. Causes of Death Study

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B. Family Health Services Delivery Component

1. Improved FHS and birth spacing service delivery through government health centers and clinics
2. Family Health Specialty Training Program

C. Grants to Non-Governmental Organizations

1. Support to National Population Commission
2. Support to JAFPP and Services Expansion

END OF PROJECT STATUS(EOPS).

1. MOH incorporating current PHC service delivery costs and revenues into annual planning process.
2. Assessment of client revenues and recurrent cost completed. MOH testing alternative cost recovery programs.
3. Increased number of private physicians providing primary health care services.
4. MOH developing health strategy with new policy directions.
5. Up to 250 primary health care centers providing improved services in health care delivery and birth spacing.
6. Curriculum and certification standards for family health specialty developed.
7. Up to 700 community health workers providing birth spacing information and education.
8. JAFPP and other NGOs able to manage and expand clinical program of birth spacing services delivery.
9. NPC regularly generating reports concerning impact of demographic variables.

In addition to the Project Paper Logframe indicators as listed above, benchmarks and indicators are also included in the cooperative agreement workplans.

V. Statement of Work

The team will conduct a mid-term evaluation of the FHS project components and activities which will provide USAID/Jordan with a detailed analyses of the project status. Particular attention will be given to the role of the FHS project in contributing to Mission's Strategic Objective Number 3, "Increased Practice of Modern Family Planning Methods". The team will identify and provide an analysis of problems and accomplishments and make specific recommendations as to how the project can assist in meeting the SO of Increased Practice of Modern Family Planning Methods through the remainder of the project. The evaluation will contain, but not be limited to the following:

- progress in attaining purpose level-objectives and end-of-project status;
- an analysis of the indicators being used to measure progress towards the purpose, with special emphasis on improving the quality of the services;

- recommended changes, if necessary, in indicator monitoring for the purpose level of the project and the indicators being used in the cooperative agreements;
- analysis of the management of inputs;
- analysis of institutional performance and relationships;
- assessment of adequacy of training impact;
- the effectiveness of technical assistance in terms of content, coordination, appropriateness and recommendations for improvement with special attention towards transferring skills;
- assess the status of each of the cooperative agreement workplans towards meeting their objectives.
- Determination of the extent to which the project contributes to the Mission's "Increased Practice of Modern Family Planning Methods" Strategic Objective, Result Packages, and performance indicators and make specific recommendations as to what steps USAID/MOH should take to bring this project in line with the new strategic objectives.

VI. Methods and Procedures

A. Data Sources. Listed below are the documents that should be reviewed.

Project Papers and Project Agreements for:
Family Health Services Project
Marketing of Birth Spacing Project
Comprehensive Post Partum Project

Cooperative Agreements and workplans: Pathfinder,
Brown University,
URC/Human Services,

NPC Grant Agreement

Memorandum of Understanding between the Faculty of Medicine, University of Jordan, and Brown University, Dept. of Family Medicine, Dec. 1 1993
Brown University Workplan, Feb.22, 1994 Revision
Brown University Quarterly Report, July 1, 1995 - September 30, 1995
Quality of Care Needs Assessment in JAFPP Clinics, Dr. Aysen Bulut, Pathfinder, May 20 - 29, 1992.
Pathfinder Quarterly Report, July 1, 1995 - September 30, 1995
Jordan Population and Family Health Survey, 1990
Jordan National Population and Housing Census, 1994 (preliminary results, if available)
USAID/Jordan/PFH Strategic Objective Framework, Results Packages and Performance Indicators

B. Methods of data collection

1. Desk Review. The cooperative agreements, workplans, and relevant trip reports are available from the cooperating agencies in the US. Other documents should be obtained from the Population/Family Health Office, USAID Jordan.

2. Interviews. One member of the team should contact the following individuals to arrange interviews:
a. Pathfinder, Dr. Turkiz Gokgol, Istanbul, Turkey. Tel: 90-216-355-1173, Fax: 90-216-363-5961.
b. Dr. Vincent R. Hunt, Brown University, Memorial Hospital of Rhode Island, Dept. of Family Medicine, 111 Brewster Street, Pawtucket, RI, 02860. Tel: 410-729-2249, Fax: 410-729-2923
c. Dr. David Nicholas, Quality Assurance Project, URC/Center for Human Services, 7200 Wisconsin Ave. Suite 600 Bethesda, MD 20814. Tel: 301-654-8338. Dr. Walid Abubaker, Resident Advisor, PO Box, 850686, Amman, Jordan. Tel: 962-6-693-104 ext. 101, Fax: 962-6-693-052
d. USAID/Jordan, PFH Officer Eilene Oldwine and Project Officer Dr. Salwa Bitar will arrange appropriate interviews with the Jordanian institutions and Ministry of Health.

3. Field Visits. Field visits should be made to the following sites outside of Amman:
a. Salt Hospital and Model Primary Health Care Center, Salt.
b. Jordanian University for Science and Technology (JUST), Irbid.
c. Jordan Association for Family Planning and Protection clinics in two of the four following cities: Irbid, Mafrak, Madaba and Russeifa.

C. Duration and Timing.

1. Start O/A January 20, 1995; end February 20, 1995
2. Preparation - 1 week - 3 days in the U.S; 2 days in Amman, Jordan
3. Field work - 1 week
4. 1st draft of evaluation report - 1 week
5. Final evaluation report - 1 week (in U.S. for expatriates and in Jordan for the local consultant.)

Prior to departure from Jordan the team will debrief the mission and provide 5 copies of the draft evaluation report for comments by USAID. USAID will respond with the Mission's comments to the team leader within 2 weeks of the team's departure from Jordan.

The evaluation team will produce a final evaluation report within two weeks of receiving written comments from the Mission. Twenty copies of the final report will be submitted to the Mission along with a diskette containing the final version of the report in WordPerfect Window version.

D. Format of Report. The evaluation report should follow the general structure as outlined below:

- Abstract (not to exceed length provided for in the USAID P.E.S. form).
- Executive Summary (not to exceed length provided for in the USAID P.E.S. form)
- The main report will cover:
  a) F.H.S. delivery
  b) Family Health medicine specialty
  c) JAFPP Expansion
  d) NPC IEC strategy
- Financing
- Management

The following topics should be discussed under each of the above headings: Status, accomplishments, problems, findings and conclusions, recommendations, and lessons learned. The short-term effects and the probability for sustained impact of the project should also be estimated.

- An essential section of the report should be: Future actions/recommendations which will support and lead to attaining the Strategic Objective "Increased Practice of Modern Family Planning Methods.
- The body of the report should not exceed fifty (50) pages, however, additional information may be contained in annexes to the report.
- The report should be prepared using W.P 5.2 for windows, Lotus 4.0 for windows, the standared software packages used in USAID/Jordan.

VII. Team Composition

The team will be composed of two U.S. and one Jordanian specialists as follows: (1) family planning program manager/team leader (U.S.); (2) quality assurance expert (U.S.); and, (3) primary health care/hospital specialist (Jordanian). All team members must possess excellent English oral and communications skills and be familiar with WordPerfect wordprocessing. Arabic language skills are useful but not required. Experience working in an Arab country and knowledge of the culture of the area is also very desirable. The team will provide its own secretarial and logistics support.

1. Family Planning Program Manager/Team Leader (Expatriate): This person will be responsible for coordinating the activities of all team members, establishing the work schedule and serving as liaison with USAID/Jordan, cooperating agencies and host country institutions and preparation of the final report. He/she should have ten years experience in international family planning program management with experience in project design and evaluation. A graduate degree in population or public health is

required.

2. Quality Assurance Specialist (Expatriate). This person will be responsible for assessing the FHS service delivery improvement and cost reduction aspects of the program, including the establishment of the Family Medicine teaching program and other training activities. He/she will be a medical doctor or a nurse practitioner with experience in latest quality assurance, improvement and management techniques and cost efficiency measures. He/she will have ten years of experience in teaching or managing quality assurance programs, including developing clinical protocols, and service delivery standards, and have a degree in medicine or be a registered Nurse Practitioner with same experience as above.

3. Primary Health Care/Hospital Service Delivery Specialist (Jordanian). This specialist will be responsible for evaluating the project methodologies and plans in terms of their appropriateness to local conditions and requirements. He/she will have a thorough understanding of health care problems and issues in Jordan and have a minimum of ten years experience in related areas. A medical degree or masters degree in public health administration is required.

APPENDIX B

LIST OF DOCUMENTS REVIEWED

USAID/FHS Project

USAID/Jordan, Balakrishnan, P. Family Health Services Project:-278-0274 Project Paper Supplement. Action Memorandum for the Mission Director 9 pp. 20 August 1991.

USAID/Jordan "Project Financial Status Report: Family Health Services Project", Amman Jordan, January 30, 1996.

USAID/Jordan "Project Paper: Family Health Services". Amman, Jordan, August, 1990.

USAID/Jordan "Project Paper Supplement: Family Health Services". Amman, Jordan, August, 1991.

USAID/Jordan "Project Grant Agreement: Family Health Services". Amman, Jordan, September, 1991.

USAID/Jordan "Cooperative Agreement No. 278-0287-A-SS-2008-00: Family Health Services Project with Pathfinder, International Amman, Jordan June 29,1992

USAID/Jordan "Program Description, Family Health Services Project No. 278-0287. Assistance to the Jordan Association for Family Planning and Protection: Extension Program Description July 1, 1995 - June 30, 1997"

USAID/Jordan "Project Grant Agreement, Amendment No. 1: Family Health Services". Amman, Jordan, March 1993.

USAID/Jordan "Project Grant Agreement, Amendment No. 2: Family Health Services". Amman, Jordan, September 1994.

USAID/Jordan "Project Grant Agreement: Jordan Family Health Services Project" with National Population Commission Amman, Jordan May 21, 1995.

USAID/Jordan "Project Paper: Comprehensive Postpartum Project," Amman, Jordan

USAID/Jordan "Project Implementation Reports: Family Health Services Project", Amman, Jordan, September 30, 1991, June 30, 1992, September 30, 1992, March 31, 1993, September 30, 1993, March 31, 1994, September 30,1994, March 31, 1995.

USAID and Brown University. "Cooperative Agreement: "Family Health Services Project", Amman Jordan, August 1, 1993.

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USAID and National Population Commission. "Grant: Family Health Services Project", May 1, 1995.

USAID and Pathfinder International. "Cooperative Agreement: Family Health Services Project", July 1, 1992.

USAID and Pathfinder International. "Cooperative Agreement Modification No. 2: Family Health Services Project", June 26, 1995.

USAID/Washington, URC's QAP Midterm Evaluation Report, Washington, D.C. August 1994

Family Health Service/Quality Assurance Project

URC/QAP-Jordan, Abubaker,W. "Background Brief, USAID/MOH FHS/QAP The Hashimite Kingdom of Jordan" for His Excellency, Dr. Arif Batyneh, Minister of Health. Amman, Jordan 10 pp. 26 August 1995

FHS/QAP-Jordan "Consolidated FY94 Workplan, November 1993 - September 1994"

Ministry of Health, Jordan, "Family Health Services Project, No. 278-0287" January 1996

URC/QAP-Jordan and Ministry of Health, Progress Report on Maternal Mortality Study, January 1996

URC, Nicholas, D., Abubaker, W., Davis, J., and Kak, N. "The Quality Assurance Project, Jordan. Health Care Quality Assessment, Balqa Governorate, Jordan. Trip Report." September 18-October 18, 1992

CHS/QAP Quality Assurance Project/Center for Human Services, Bethesda, MD "A Proposal to Carry Out Activities in the Quality Assurance of Family Health Services in Jordan" Revised Version 10 pp. 30 August 1993

CHS/QAP Quality Assurance Project/Center for Human Services, Bethesda, MD "Implementation Plan to Strengthen the Quality of Family Health and Family Planning Services and to Support an Integrated Quality Assurance Program in the Ministry of Health in Jordan November 1, 1993 - September 30, 1995" DRAFT 10 pp. 27 December 1993

MOH, Balqa Governorate "Family Care Model Center. Mother, Child, Family Planning Services" Brochure in Arabic and English

URC/QAP-Jordan "Quarterly Progress Report, FHS/QA Project-Jordan October 1, 1995 - December 31, 1995"' 17 pp. 19 January 1996

URC/QAP-Jordan "Annual Action/Implementation Plan. Project to Strengthen the Quality of Family Health and Family Planning Services and to Support an Integrated Quality Assurance Program in the Ministry of Health in Jordan," March 1, 1995 - March 31, 1996. DRAFT 8 pp. April 15, 1995

URC/QAP-Jordan "Family Health Services Project/Quality Assurance Proposed Annual Workplan January 1 to December 31 1996" DRAFT

URC/QAP and USAID "Annual Report on Improving the Quality of Family Health Services in The Hashemite Kingdom of Jordan" 14pp. February 1994-February 1995

URC/QAP and USAID "The Quality Assurance Project Quarterly Report, Second Quarter, Fiscal Year 1995 9 pp. January - March 1995

URC/QAP-Jordan, Abubaker,W. "QAP Strategy IV: Assist MOH in conducting four epidemiological, unit cost and quality improvement studies Epidemiological Studies". Amman, Jordan 10 pp. 26 August 1995

URC/QAP-Jordan, Abubaker,W., FHS/QAP "Evaluation of the Training Program in QA, Balqa Governorate, MOH" October 1995, in Arabic

MOH, Al-Hussain Hospital, Salt and FHS/QAP-Jordan, "Achievements During 1994" in Arabic.

FHS/QAP-Jordan URC/CHS, Study Report "Unit Cost Analysis for Al-Hussain Hospital/Salt June 1993-May 1994" August 1995 in Arabic and summary in English.

FHS URC/CHS, Study Protocol "Unit Cost Analysis in Health Centers for Fiscal Year 1994" in Arabic

FHS/QAP-Jordan, Proposed Annual Workplan January 1 - December 31, 1996, First Draft, February 1, 1996

MOH and USAID FHS/QAP, "Quality Assurance Achievements in Balqa Governorate, Jordan," 1995

URC/QAP-Jordan and Ministry of Health, Protocol of Morbidity Study (undated)

URC/QAP-Jordan and University of Jordan, Protocol of Causes of Death Study (undated)

URC/QAP-Jordan, Integrated Family Health Model Center brochure

URC/QAP-Jordan, Statistics on Training Workshops in QA and FP

URC/QAP-Jordan and MOH, Statistics on FHS Model Center in Salt City, Balqa, January 1996

URC/QAP-Jordan, Workshops participants' evaluation summaries, January 1996

Family Medicine Specialty Training Program (FMSTP)

Brown University, Hunt, Vincent R., "Family Medicine Specialty Training Program", Quarterly Narrative Report, February 1, 1995-April 30, 1995.

Brown University, Hunt, Vincent R., "Family Medicine Specialty Training Program", Quarterly Narrative Report, May 1, 1995-July 31, 1995.

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University of Jordan and Brown University. "Memorandum of Understanding: Family Medicine Specialty Training Program", Amman, Jordan, February 10, 1994.

JAFPP

Pathfinder International, Bulut, Aysen, "Quality of Care Needs Assessment in JAFPP Clinics", Amman, Jordan, May 20-29-1992.

JAFPP, Jordan Association for Family Planning and Protection. "Statistical Report: Family Health Services Project", January, 1996.

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Pathfinder International. "Quarterly Narrative Report: Expansion of JAFPP Family Planning Activities, Family Health Services Project", Amman, Jordan, July 1, 1995-September 30, 1995.

JAFPP (Jordan Association for Family Planning and Protection), Protocol of "Loss to follow up among clients of the Jordan Association for Family Planning and Protection: Magnitude and reasons of the problem" 6 pp. undated.

JAFPP, Jordan Association for Family Planning and Protection, Report to Pathfinder International - Project JC2/001-2 Period 1.10.95-31.12.95.

JAFPP, Jordan Association for Family Planning and Protection, Report to Pathfinder International - Project JC2/001-2 Period 1.7.95-30.9.95.

National Population Commission

NPC (The Jordan National Population Commission), Amman, Jordan "The Jordan National Population Commission (JNPC) Establishment, Objectives, Functions" 5 pp. (undated)

NPC, Amman, Jordan "National Health Programme of Birth Spacing in Jordan" 6 pp. (undated)

NPC, Amman, Jordan "National Population Strategy for Jordan." DRAFT 13 pp. (undated)

World Bank

World Bank, Health Management Project, the Hasheminte Kingdom of Jordan (HKJ), Staff Appraisal Report, 1993

APPENDIX C

LIST OF PERSONS CONTACTED

USAID/Jordan

Mr. William T. Oliver, Mission Director
Ms. Diana Swain, Deputy Mission Director
Ms. Eilene Oldwine, Chief, Office of Population and Family Health
Dr. Salwa Bitar Qteit, Project Management Specialist, OPFH
Ms. Lina Qushair Khoury, Project Management Assistant, OPFH
Dr. Mahmoud Shahed, Special Consultant to the MOH on the FHS Project

Ministry of Health

Dr. Aref Bataineh, Minister of Health
Dr. Fouad Al Ayed, Director of Planning and Projects Management Directorate
Dr. Jafar Abu Taleb, Quality Assurance Coordinator, Planning and Projects Management Directorate
Dr. Riad Akour, Planning and Projects Management Directorate
Dr. Sulieman Qhewi, Director of Monitoring and Quality Assurance Directorate
Dr. Khaled Hassan, Monitoring and Quality Assurance Directorate
Dr. Hyam Al Araj, Monitoring and Quality Assurance Directorate

Balqa Governorate

Dr. Samir Awamleh, General Director of Health
Dr. Osama Samawi, Salt (Al-Hussein) Hospital Director
Dr. Mohammed Odwan, Balqa Health Director
Dr. Jamal Dabbas, Model Center Director and Quality Assurance Coordinator in Balqa
Dr. Rawhi Najdawi, Assistant to the General Health Director

Madaba Governorate

Dr. Jafar Huniti, General Director of Health
Ms. Malak Anabtawi, Quality Assurance Liaison Officer
Dr. Ghassan Khoury, Assistant to DG of Health, QA Trainee
Dr. Ragi Faris, ENT Specialist, QA Trainee
Dr. Mohamed Hussein, Surgeon, Al Nadim Hospital, QA Trainee
Staff Nurses Rajwa and Mai at Al Nadim Hospital, QA Trainees

The Jordan Association for Family Planning and Protection

Mr. Basem Abu Ra'ad, Executive Director
Dr. Zeinab Abu Sha'ar, Medical Service Director
Ms. Salma Zuibi, Quality Assurance Coordinator
Dr. Ihsan Nazer, Director of JAFPP Ashrafiah Clinic and staff
Dr. Fareeda Omar, Director of JAFPP Quesmah Clinic and staff

Jordan National Population Commission Secretariat

Mr. Nabih Salameh, Secretary General
Ms. Lina Khader Bakmerza Qardan, Communication and Information Manager

Pathfinder

Ms. Iman Baara, Jordan Coordinator

University Research Corporation

Dr. David Nicholas, Senior Technical Officer and Vice President of the International Division, Washington, D.C. (Interviewed by Ms. Cromer and Dr. Hudson)
Dr. Walid Abubaker, Project Manager, Jordan
Dr. Sana Nafa, Deputy Project Manager, Jordan
Dr. Samir Fa'ouri, Principal Investigator, Peri/Neonatal Mortality Study Manager (Chief of Pediatrics at MOH)
Dr. Sa'ed Karabsheh, Study Manager, Morbidity and Health Situation Study (Chief, Disease Control Directorate, MOH)
Dr. Diana Mas'ad, Study Manager, Cause of Death Study (Instructor at Jordan University in the Department of Community Medicine)
Dr. Tayseer Fardous, Assistant Study Manager, Cause of Death Study (PPM Directorate, MOH)

Brown University School of Medicine

Dr. Vincent R. Hunt, Department of Family Medicine (Ms. Cromer and Dr. Hudson interviewed by phone)

University of Jordan

Dr. Mahmoud Abu Khalaf, Dean, Medical School
Dr. Farihan Barghouti, Family Medicine Specialty Coordinator
Dr. Kandil Shaker, Chief, Internal Medicine; Member, Family Medicine Committee
Dr. Mohammed Qudah, Department of Surgery, Member, Family

Medicine Committee
Dr. Mahmoud Amr, Department of OB/GYN, Member Family Medicine Committee
Dr. Radi Hamed, Chief of Pediatrics, Member, Family Medicine Committee
Dr. Salah Ali and Dr. Dua'a Hamori (two residents in Family Medicine Program)

Jordan University of Science and Technology

Dr. Hashem Al-Jaddou, Head of Community Medicine and Public Health Department, and Family Medicine Coordinator
Dr. Abdullah Saada, Head Internal Medicine, Member Family Medicine Committee
Dr. Mohammed Khamash, Surgery Chief, Member Family Medicine Committee

Jordan Medical Council

Dr. Tawfik Al Loubani, Chairman
Dr. Hanna Halaby, Head of Scientific Committee on Family Medicine, and part-time faculty at Jordan University in Family Medicine
Dr. Mazen Al-Bashir, Member of Scientific Committee on Family Medicine and part-time faculty at Jordan University in Family Medicine